

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3863

CERTIFICATE OF DEATH

03838
74

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Sykesville		c. LENGTH OF STAY IN 1b 5M 12 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore - 18		d. STREET ADDRESS 1804 East 29th Street			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First ADELIN	Middle E	Last AULTHOUSE	4. DATE OF DEATH 4	Month 16	Day 19	Year 56	
5. SEX Female	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/14/76		9. AGE (In years last birthday) 79 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME George William Aulhouse		14. MOTHER'S MAIDEN NAME Adeline Warner							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Record, Springfield State Hospital		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction of the posterior left		3 days							
DUE TO ventricle wall									
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) Coronary artery thrombosis		3 days							
DUE TO (c) Arteriosclerosis		years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Manic depressive reaction, depressed type									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a. m. p. m. 19		Month 1	Day 19	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) 4/16	(County)	(State)	
21. I certify that I attended the deceased from 4/9/ , 19 56 , to 4/16 , 19 56 , that I last saw the deceased alive on 4/15 , 19 56 , and that death occurred at 2:15 AM , from the causes and on the date stated above.		ADDRESS (Street, city or town, state)						DATE SIGNED	
ACTUAL SIGNATURE <i>Agustin del Campo</i>		Sykesville, Maryland						4/16/56	
PHYSICIAN'S NAME (Type) Agustin del Campo, M. D.									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-19-1956		22c. NAME OF CEMETERY OR CREMATORIUM Mount Olivet		22d. LOCATION (City, town, or county) Baltimore, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Lassabu Funeral Home</i>		ADDRESS 7401 Belair Rd.		24a. REC'D BY REGISTRAR DATE 4/18/1956		24b. REGISTRAR'S SIGNATURE <i>C. Harry Weisz</i>			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3864

CERTIFICATE OF DEATH

03839

Reg. Dist. No.

70

1. PLACE OF DEATH a. COUNTY Carroll		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Carroll			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Taneytown		c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Taneytown Rural		d. STREET ADDRESS 			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 				d. STREET ADDRESS 		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) George William Baker		First	Middle	Last	4. DATE OF DEATH April 4, 1956	Month	Day	Year	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH June 7, 1888	9. AGE (In years lost birthday) 67 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired laborer		10b. KIND OF BUSINESS OR INDUSTRY Feed warehouse		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME John W. Baker		14. MOTHER'S MAIDEN NAME Mary Alice Nusbaum							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 213-12-7874		17. INFORMANT Harry E. Baker, Taneytown, Maryland R.D.		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1		DUE TO <i>Coronary Occlusion</i>		INTERVAL BETWEEN ONSET AND DEATH					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)		DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. g. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Union Bridge		(County) Md.	(State) 4-6-56
21. I certify that I attended the deceased from Mar 25, 1956 , to 4-4-1956 , that I last saw the deceased alive on Apr 2, 1956 , and that death occurred at 10 AM , from the causes and on the date stated above.				ADDRESS (Street, city or town, state) Union Bridge Md - 4-6-56					DATE SIGNED
ACTUAL SIGNATURE J. H. Legg		M.D.							
PHYSICIAN'S NAME (Type) J. H. Legg MD									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 7, 1956		22c. NAME OF CEMETERY OR CREMATORIUM Lutheran Cemetery		22d. LOCATION (City, town, or county) Taneytown, Carroll, Maryland		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Merwyn C. Fuss		ADDRESS Taneytown, Maryland		24a. REC'D BY REGISTRAR DATE April 9/56		24b. REGISTRAR'S SIGNATURE Ethel M. Mahring			

WILL, AND STATE GOVERNMENT OF HAWAII - GOVERNOR'S OFFICE

CERTIFICATE OF DEATH

BUREAU V. S.
RECEIVED
APR 11 1956

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3865

CERTIFICATE OF DEATH

03840

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Sykesville		c. LENGTH OF STAY IN lb Ynk -		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		d. STREET ADDRESS 7509 MacArthur Boulevard		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First MARGARET	Middle OLIVIA	Last BAKER	4. DATE OF DEATH April 21 1956	Month April	Day 21	Year 1956
5. SEX Female	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH 5/28/83	9. AGE (In years less birthday) 72 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0
8. OCCUPATION (Give kind of work done during most of working life, even if retired) Seamstress		10b. KIND OF BUSINESS OR INDUSTRY Ynk -		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Graffton A. DuVall				14. MOTHER'S MAIDEN NAME Molly Peters			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. unknown		17. INFORMANT Record, Springfield State Hospital		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Nephrosis due to remote infection DUE TO 591X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Chronic brain syndrome assoc. with cerebral arteriosclerosis with psychosis <input type="checkbox"/> NO <input checked="" type="checkbox"/> PERFORMED?							
INTERVAL BETWEEN ONSET AND DEATH 3 days							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Chronic brain syndrome assoc. with cerebral arteriosclerosis with psychosis <input type="checkbox"/> NO <input checked="" type="checkbox"/> PERFORMED?					
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Day	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Fredrick	(County) Maryland
21. I certify that I attended the deceased from 4/18 1956 , to 4/21 1956 , that I last saw the deceased alive on April 21 1956 , and that death occurred at 11:54 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Sykesville, Maryland DATE SIGNED Walther H. Sonnenfeldt							
ACTUAL SIGNATURE Walther H. Sonnenfeldt		DATE SIGNED Walther H. Sonnenfeldt					
PHYSICIAN'S NAME (Type) Walther H. Sonnenfeldt							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 4-56	22b. DATE THEREOF 4/21/56	22c. NAME OF CEMETERY OR CREMATORIAL Mt Olivet		22d. LOCATION (City, town, or county) Fredrick		(State) Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert E. Humphrey - Bethesda Md.		ADDRESS		24a. REC'D BY REGISTRAR C. Harry Weller		24b. REGISTRAR'S SIGNATURE C. Harry Weller	
VS A15 (4) 15M 9/55		DATE 4-23-56		DATE 4-23-56			

WISCONSIN STATE DEPARTMENT OF HEDDING - EAU CLAIRE 18

CERTIFICATE OF DEATH

BUREAU V. S.

APR 24 1956

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03841

74

3866

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County... **Carroll**City or town... **Silver Run**

(If outside city or town limits, write RURAL and give nearest town)

Yrs.

How long in above place of death?

Hospital, institution, or street address where death occurred: **Residence**

How long in hospital or institution?

3. (a) FULL NAME

Frederick Charles Bayner

4. Sex

M

5. Color or race

W

6.(a) Single, married, widowed, or divorced

Widowed6.(b) Name of husband or wife... **Mary Smith Bayner**7. Birth date of deceased (mo. day, yr.) **2/1/1872**

6.(c) If alive, give age..... years

8. AGE: Years **84** Months Days If less than one day hrs. min.9. Birthplace... **Md.**
(Town, county, and state)

10. Usual occupation.....

11. Industry or business.....

12. Name... **Godfred Bayner**

13. Birthplace.....

14. Maiden name... **Unknown**

15. Birthplace.....

16. Informant... **Mrs. Mildred Ireland**
Address **Silver Run, Md.**17. Burial..... Date thereof..... **4/10/56**
(Burial, cremation, or removal. Which?) **Glen Haven**

Cemetery or crematory.....

Location... **Baltimore**18. Funeral director... **McCully Funeral Home**
Address **130 E. Fort Ave.**19. (Date rec'd by registrar) **4-7-56** **19-56** **Dal H. Head**
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... **Maryland** County... **Carroll**City or town... **Silver Run, Md.**

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war... **No.**

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH... **APRIL 7** 19-56, at **9:10A.M.**

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

DEC 15 19-55 to **APRIL 6** 19-56and that I last saw him **alive** on **APRIL 6** 19-56

Immediate cause of death.....

CA OF THE RT LUNG

Due to.....

Due to.....

Other conditions **NUTRITIONAL ANEMIA-**
ATHEROSCLEROTIC CARDIOVASCULAR
RENAL DISEASE **2105**
(Include pregnancy within 3 months of death) **7129**

Major findings or operations.....

Autopsy results..... Date of op.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

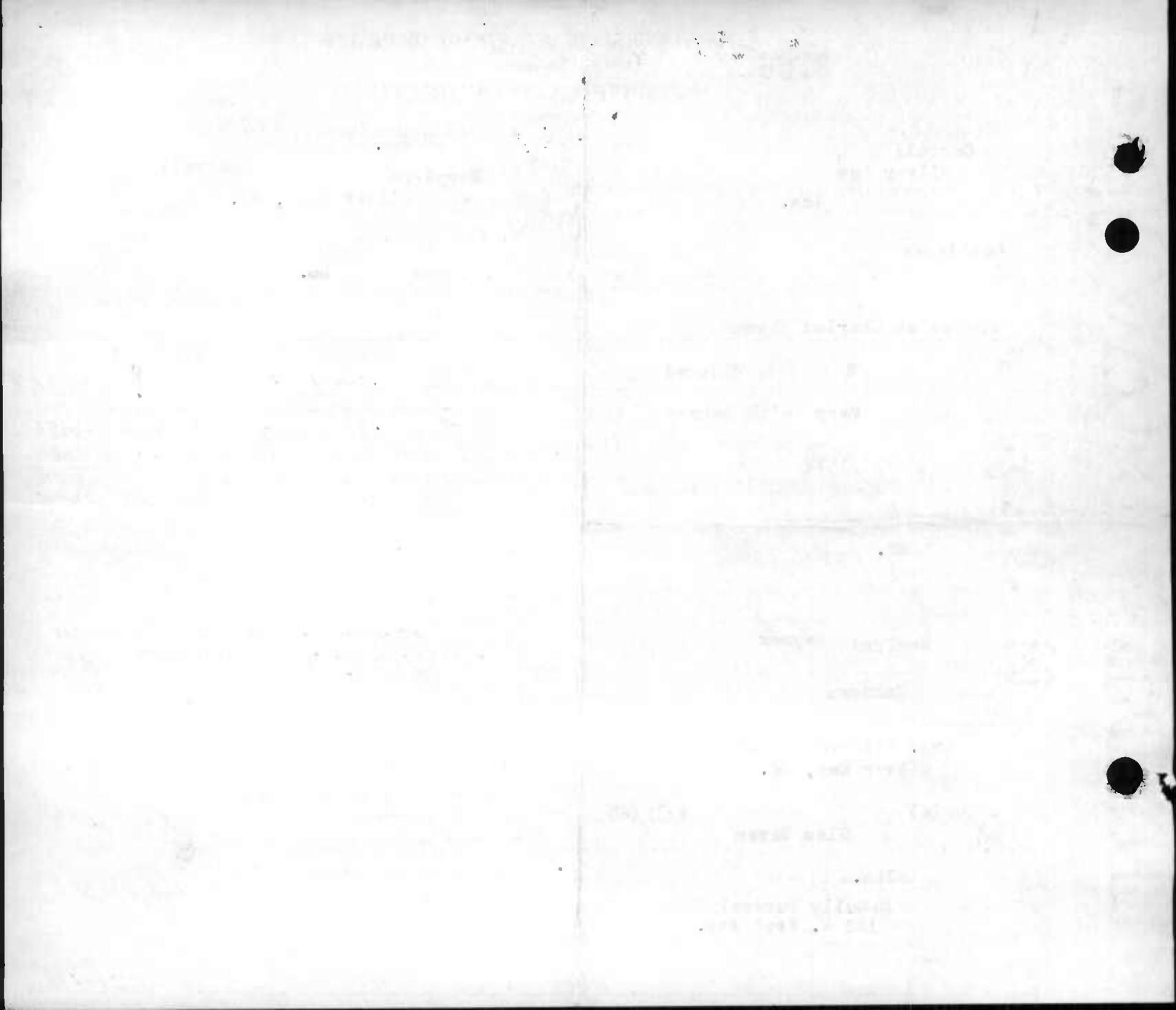
Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury..... Injured at work?

23. SIGNATURE... **Philip A. Zulich M.D.** M. D. or otherAddress... **Luthan Jr.** Date signed **4/7/56**



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03842

3867

CERTIFICATE OF DEATH

Reg. Dist. No.

74

1. PLACE OF DEATH o. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE	
<i>Carroll</i> MARYLAND		Md.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Sykesville</i>		c. LENGTH OF STAY IN 1b <i>79 years</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Sykesville</i>	
3. NAME OF DECEASED (Type or print)		First <i>EUGENE CLIFTON</i>	Middle <i>BERRY</i>
4. DATE OF DEATH	Month <i>April</i>	Day <i>9</i>	Year <i>1956</i>
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH
<i>M</i>	<i>W</i>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<i>March 1, 1877</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)
<i>Grocer - Retired</i>		<i>Food store</i>	<i>Md.</i>
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
<i>John Berry</i>		<i>Charlotte Hayworth</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES (Yes, no or unknown)		16. SOCIAL SECURITY NO.	17. INFORMANT
<i>No</i>		<i>None</i>	<i>Mr. E. L. Berry - Sykesville, Md.</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		<i>CORONARY ThromBosis</i>	
420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost.		Dec. 55	
(b) DUE TO ARTERIOSCLEROTIC Heart Disease		9 APR 1956	
(c) PULMONARY EDema			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
19			
21. I certify that I attended the deceased from <u>DEC</u> , 19 <u>55</u> , to <u>APR 11</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>8 APR 11</u> , 19 <u>56</u> , and that death occurred at <u>12:00 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Howard E. Hall</i>		ADDRESS (Street, city or town, state) <i>Sykesville, Md.</i>	
PHYSICIAN'S NAME (Type) <i>HOWARD E. HALL</i>		DATE SIGNED <i>4-9-56</i>	
220. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>4-11-56</i>	22c. NAME OF CEMETERY OR Crematory <i>Springfield</i>	22d. LOCATION (City, town, or county) (State) <i>Sykesville, Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Salter Hartright - Sykesville, Md.</i>	ADDRESS	24a. REC'D BY REGISTRAR DATE <i>11-10-56</i>	24b. REGISTRAR'S SIGNATURE <i>C. Harry Weir</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after
may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DEPARTMENT OF STATE - BUREAU OF INTELLIGENCE
CERTIFICATE OF DEATH

SEARCHED

INDEXED

SERIALIZED

FILED

BUREAU V.

APR 13 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
3868 CERTIFICATE OF DEATH

03843

Reg. Dist. No.

74

1. PLACE OF DEATH a. COUNTY Carroll				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland											
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville, Maryland		c. LENGTH OF STAY IN 1b 8mos. 9days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster		d. STREET ADDRESS Sullivan Road - Route #3									
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First Amelia		Middle Catherine		Last Bish		4. DATE OF DEATH Month 4 Day 12 Year 19 56									
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12-18-1866									
9. AGE (In years lost birthday) 89 yrs.						10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. KIND OF BUSINESS OR INDUSTRY Home		12. BIRTHPLACE (State or foreign country) Maryland		13. CITIZEN OF WHAT COUNTRY? U.S.A.			
14. FATHER'S NAME Ephrian Feeser										15. MOTHER'S MAIDEN NAME Sara Weibling					
16. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Y/N				17. SOCIAL SECURITY NO. ---		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. Generalized arteriosclerosis				19. INFORMANT Unk.		Address Hospital Records - Sykesville, Md.			
												INTERVAL BETWEEN ONSET AND DEATH 1 hr.			
20. MEDICAL CERTIFICATION															
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ---						20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 --- p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ---	
												20f. (City or town) ---			
												(County) ---			
												(State) ---			
21. I certify that I attended the deceased from alive on 4-12-1956 , and that death occurred at 5:05A.M. from the causes and on the date stated above.												ADDRESS (Street, city or town, state) ---			
												DATE SIGNED 4-12-56			
ACTUAL SIGNATURE J. M. Little & Son															
PHYSICIAN'S NAME (Type) Ilse Kamm, M.D.															
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/14/56		22c. NAME OF CEMETERY OR CREMATORIUM St. Marys Cemetery		22d. LOCATION (City, town, or county) Silver Run, Carroll Co., Md.									
23. FUNERAL DIRECTOR'S SIGNATURE J. M. Little & Son		ADDRESS Littlestown, Pa.		24a. REC'D BY REGISTRAR Ap. 14, 1956		24b. REGISTRAR'S SIGNATURE C. Harry Zeller									

MICHIGAN STATE DEPARTMENT OF HEALTH - DIVISION OF

CERTIFICATE OF DEATH

NAME:

ADDRESS:

CITY:

STATE:

ZIP CODE:

PHONE NUMBER:

DEATH DATE:

AGE:

SEX:

CAUSE OF DEATH:

TIME OF DEATH:

TIME OF REPORT:

TIME OF AUTOPSY:

TIME OF EXAMINATION:

TIME OF CERTIFICATION:

TIME OF ISSUANCE:

TIME OF DELIVERY:

TIME OF RECEIPT:

TIME OF EXPIRATION:

RECEIVED

APR 17 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03844

3869

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Carroll		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland		b. COUNTY —	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Sykesville		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City		d. STREET ADDRESS 828 N. Lakewood Avenue	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Jacob	Middle —	Last BITTEL	4. DATE OF DEATH April 23 1956	Month Year	Day	Year
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH December 3, 1876	9. AGE (In years less years.) 79	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tin shop worker		10b. KIND OF BUSINESS OR INDUSTRY Tinning		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? United States	
13. FATHER'S NAME John Bittel		14. MOTHER'S MAIDEN NAME Mary Schuchard					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. unknown		17. INFORMANT Records of Springfield State Hospital		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction DUE TO 420.1						INTERVAL BETWEEN ONSET AND DEATH immediate	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) _____ DUE TO (c) _____						years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Senile psychosis, simple deterioration						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) —					
20c. TIME OF INJURY Month, Day, Year Hour a. m. —— p. m. —— 19		20d. INJURY OCCURRED While —— Not while at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept. 1st, 1947 , to April 23, 1956 , that I last saw the deceased alive on April 23, 1956 , and that death occurred at 10:55 AM , from the causes and on the date stated above. ACTUAL SIGNATURE Martin Gross				ADDRESS (Street, city or town, state) Sykesville, Maryland		DATE SIGNED 4-25-56	
PHYSICIAN'S NAME (Type) Martin Gross, M. D.		22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 4/26/56		22c. NAME OF CEMETERY OR CREMATORIAL HOLY CROSS	
23. FUNERAL DIRECTOR'S SIGNATURE Clarence F. Hoffmann		ADDRESS 3218 Hudson St		24a. REC'D BY REGISTRAR APR 27 1956 DATE		24b. REGISTRAR'S SIGNATURE C. Harry Weers	

MISSOURI STATE DEPARTMENT OF HEALTH - DIVISION OF

CERTIFICATE OF DEATH

RECEIVED APR 27 1956

BUREAU V.

APR 27 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03845

3870

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH o. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City	
3. NAME OF DECEASED (Type or print) First John Middle Bosley Last		4. DATE OF DEATH Month April, 7th Day Year 1956	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH June 27, 1908
9. AGE (In years last birthday) 67 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) clerk		10b. KIND OF BUSINESS OR INDUSTRY B&O Railroad Co.	
11. BIRTHPLACE (State or foreign country) Baltimore		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Bossley		14. MOTHER'S MAIDEN NAME Ida Williams	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT Records of Springfield State Hospital		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH 2 hours	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 350X		Cerebro-vascular accident	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last.		DUE TO Parkinsonian Syndrome Status after lobotomy 22 years	
(b)		(c)	
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
Psychosis with organic brain disease			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While Nat while at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from February 1953 to April 6th, 1956, that I last saw the deceased alive on April 6th, 1956, and that death occurred at 655A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE M. Mastin M.D.		ADDRESS (Street, city or town, state) Sykesville DATE SIGNED 4/7/56	
PHYSICIAN'S NAME (Type)			
22a. BURIAL/CREMATION, REMOVAL (Specify) DNR		22b. DATE THEREOF 4-10-56	
22c. NAME OF CEMETERY OR CREMATORIAL GREENMOUNT		22d. LOCATION (City, town, or county) BALTO CITY (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Heilefeld & Son		ADDRESS	
24a. REC'D BY REGISTRAR DATE		24b. REGISTRAR'S SIGNATURE C. Harry Heilefeld APR 9 1956	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after the deceased has been removed by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-trust permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

THE STATE DEPARTMENT OF HEALTH—STUTTGART 18

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APR 10 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03846

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CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH o. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE Maryland b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Henryton		c. LENGTH OF STAY IN 1b 46 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Henryton State Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown 14 x 2 ✓	
3. NAME OF DECEASED (Type or print)	First David	Middle	Last Brown
4. DATE OF DEATH April 16	Month	Day	Year 19 56
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 7, 1892
9. AGE (In years lost birthday) 63 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Farm	11. BIRTHPLACE (State or foreign country) Chestertown, Maryland
		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John Brown		14. MOTHER'S MAIDEN NAME Jane Thomas	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 218-24-2536	17. INFORMANT David Brown - Rt. 3, Chestertown, Maryland
		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of prostate 177x			
DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Minimal pulmonary tuberculosis			
DUE TO			
(c)			
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from March 1, 1956, to April 16, 1956, that I last saw the deceased alive on April 16, 1956, and that death occurred at 2:15 P.M., from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED Henryton, Maryland 4-16-56	
ACTUAL SIGNATURE <i>T. F. Vestal</i>		M.D.	
PHYSICIAN'S NAME (Type) Dr. Tom F. Vestal		Henryton, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF 4-21-56	22c. NAME OF CEMETERY OR CREMATORIUM Pomona Cemetery
22d. LOCATION (City, town, or county) Chestertown Route 3 Md		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>James B. DeShell - Easton Md</i>		24a. REC'D BY REGISTRAR DATE 4-16-56	24b. REGISTRAR'S SIGNATURE <i>Albert R. Swanson</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after the funeral director, or funeral director, after this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3872

CERTIFICATE OF DEATH

038474

Reg. Dist. No.

Page 4
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the time of death.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Carroll		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md.		b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville - Rural.		c. LENGTH OF STAY IN 1b 7 Weeks		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore.		3. STREET ADDRESS 1139 W. Lombard St.		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Grand View Mansion Rest Home				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Meda		First Vernon	Middle Brown	Lost	4. DATE OF DEATH April 7th	Month	Day	Year 1956
5. SEX Female	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Nov. 9, 1878	9. AGE (In years lost birthday) 77 yrs.	IF UNDER 1 YEAR 4 Months	IF UNDER 24 HRS. Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Home Duties		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Martinsburg, W. Va.		12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME William Schlinkmann			14. MOTHER'S MAIDEN NAME Sarah Chambers					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service)			16. SOCIAL SECURITY NO. none		17. INFORMANT W. Roland Brown	Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage, middle meningeal artery, left INTERVAL BETWEEN ONSET AND DEATH 443X DUE TO 2 months Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive cardiovascular disease several years (c) General arteriosclerosis several years								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	Doy	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I attended the deceased from 18 February, 1956 , to 7 April, 1956 , that I last saw the deceased alive on 7 April, 1956 , and that death occurred at 2:45 PM , from the causes and on the date stated above. ACTUAL SIGNATURE <i>W.H. Lawson</i> ADDRESS (Street, city or town, state) Liberty Road at Eldersburg DATE SIGNED 4/7/56 PHYSICIAN'S NAME (Type) Wm. H. Lawson, Jr., M.D. Sykesville P.O., Maryland								
22a. BURIAL, CREMATION, REMOVAL (Specify) Rural	22b. DATE THEREOF 4/10/1956	22c. NAME OF CEMETERY OR CREMATORIUM Loudon Park	22d. LOCATION (City, town, or county) (State) Baltimore					
23. FUNERAL DIRECTOR'S SIGNATURE <i>Fred. H. Cole</i>		ADDRESS 1913 W. Baltimore St.	24a. REC'D BY REGISTRAR DATE App 9 1956	24b. REGISTRAR'S SIGNATURE C. Harry Her.				

BUREAU V. S.

APR 9 1956

REFUGEE ED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 03848

3873 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH: COUNTY CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		LENGTH OF STAY (in this place) 5 years	
3. NAME OF DECEASED: (Type or Print)		(First) NELSON D	(Middle) (Last) CARR
4. SEX: RACE:		5. COLOR OR RACE: (Specify): White	6. MARRIED WIDOWED, DIVORCED: Married
7. DATE OF BIRTH: 105. KIND OF BUSINESS OR INDUSTRY: 106. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		8. DATE OF BIRTH: 9/12/1880	
107. INFORMANT & ADDRESS: 108. MOTHER'S MAIDEN NAME: 109. BIRTHPLACE (State or foreign country): Michigan U.S.		9. AGE last birthday 75 yrs. 7 months 21 days 19 hours 45 min.	
110. CITIZEN OF WHAT COUNTRY?		111. INTERVAL BETWEEN ONSET AND DEATH	
13. FATHER'S NAME: William J. Carr		112. SOCIAL SECURITY NO.: none	
14. MOTHER'S MAIDEN NAME: Eloise Palmer		113. INFORMANT & ADDRESS: Laura C. Carr, Woodbine, Md	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. MEDICAL CERTIFICATION I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 420 IMMEDIATE CAUSE Antecedent cause (8): Diseases or conditions, if any, giving rise to the above cause stating underlying cause last.	
		(A) DUE TO Coronary Thrombosis etc. 1 hr	
		(B) DUE TO Chro - Arterio - Sclerosis - 10 years	
		(C) DUE TO Chro. Mitral regurgitation 10 yrs	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While Not while at work at work		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>March 15</u> to <u>April 15</u> , 1956, that I last saw the deceased alive on <u>April 4</u> , 1956 and that death occurred at <u>607 M.</u> from the causes and on the date stated above. SIGNATURE <u>S. Hunter Barr M.D.</u> ADDRESS <u>Wilmington, Md.</u> DATE SIGNED <u>4/4/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <input checked="" type="checkbox"/> Burial		DATE THEREOF <u>7/7/56</u> NAME OF CEMETERY OR CREMATORIAL <u>Cedar Hill Cemetery</u> LOCATION (City, town, or county) <u>Wilmington, Md.</u> (State) <u>Delaware</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE <u>E. Pearl Munsey</u> 24. FUNERAL DIRECTOR ADDRESS <u>Valley Funeral Home</u> <u>3200 E. Love St.</u> Mt. Rainier, Md.	

RECEIVED
APR 26 1956

BUREAU X. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
CERTIFICATE OF DEATH

03849

Reg. Dist. No.

3874

1. PLACE OF DEATH a. COUNTY Carroll		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Sykesville		c. LENGTH OF STAY IN lb 42Y 9M 15D		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		d. STREET ADDRESS 3 Vol-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First ANGELOS	Middle	Last CHALDIS	4. DATE OF DEATH	Month 4	Day 22	Year 19 56
5. SEX Male	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH unknown	9. AGE (In years last birthday) 64 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Greece		12. CITIZEN OF WHAT COUNTRY? Greece-4683162	
13. FATHER'S NAME unknown		14. MOTHER'S MAIDEN NAME unknown		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no 16. SOCIAL SECURITY NO. (If yes, give war or date of service) none 17. INFORMANT Record, Springfield State Hospital Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic glomerulonephritis 592X DUE TO				INTERVAL BETWEEN ONSET AND DEATH years			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) Malignant hypertension DUE TO				years			
DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Schizophrenic reaction, catatonic type, long-standing				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. p. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Sykesville	(County) Maryland (State) MD
21. I certify that I attended the deceased from 4/18 , 19 56 , to 4/22 , 19 56 , that I last saw the deceased alive on 4/22 , 19 56 , and that death occurred at 2:55 P.M. from the causes and on the date stated above.				ADDRESS (Street, city or town, state) Sykesville, Maryland		DATE SIGNED 4/23/56	
ACTUAL SIGNATURE <i>Walther H. Sonnenfeldt</i>	M.D.						
PHYSICIAN'S NAME (Type) Walther H. Sonnenfeldt, M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4/24/56	22c. NAME OF CEMETERY OR CREMATORIAL Sacred Heart	22d. LOCATION (City, town, or county) Baltimore		(State) MD		
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. J. Laffey Sons</i>		ADDRESS 1318 Light	24a. REC'D BY REGISTRAR John Steers	24b. REGISTRAR'S SIGNATURE John Steers			
			DATE 24 1956				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after it may be retained by hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

81.3% of women aged 16-49 years old have been pregnant at least once.

BUREAU V.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3875

CERTIFICATE OF DEATH

03850

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY CARROLL		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WESTMINSTER RURAL		c. LENGTH OF STAY IN 16 2 MONTHS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION GLOVER NURSING HOME		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) IDA VIRGINIA CRABBS		First	Middle
4. DATE OF DEATH APRIL 11 1958		Month	Day Year
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH NOV 26 1867
9. AGE (In years last birthday) 88 yrs.		10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	11. BIRTHPLACE (State or foreign country) MARYLAND
13. FATHER'S NAME JOHN SLIMMER		14. MOTHER'S MAIDEN NAME MARGARET SLIMMER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. none	17. INFORMANT RALPH M GRABBS LINWOOD MD
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 332X DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. 9049		INTERVAL BETWEEN ONSET AND DEATH 2 yrs + 9 mos	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) Fracture sural nerve left thigh		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II or Item 18.) Sural nerve left thigh	
20c. TIME OF INJURY Hour o. p.m.	Month 19	20d. INJURY OCCURRED White at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Feb 20, 1956 until 1958 , that I last saw the deceased alive on Apr 11, 1956 , and that death occurred at 7 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Westminster 47 DATE SIGNED Reese Wilkins M.D.			
ACTUAL SIGNATURE Reese Wilkins M.D.		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
22b. DATE THEREOF April 14, 1958		22c. NAME OF CEMETERY OR CREMATORIAL Pine Creek	
22d. LOCATION (City, town, or county) Carroll Co Md		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE W.H. Hartley & Sons Union Bridge Md		24a. REC'D BY REGISTRAR DATE 4-13-58	
		24b. REGISTRAR'S SIGNATURE Harold Nutt	

CERTIFICATE OF DEATH

DEATH

BUREAU V. S.
APR 16 1956
RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03851

3876

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH a. COUNTY Carroll		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Carroll			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Marriottsville		c. LENGTH OF STAY IN 1b 25 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Marriottsville		d. STREET ADDRESS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 100						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First ANNIE	Middle CUSTIS	Last 	4. DATE OF DEATH April 16	Month 1956	Day 	Year 	
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-3-1898		9. AGE (In years last birthday) 57 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours 	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Catonsville, Md		12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Howard Robinson				14. MOTHER'S MAIDEN NAME Mary Tyler					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. ?		17. INFORMANT Marie Custis Marriottsville, Md		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c)		Cerebral Hemorrhage				INTERVAL BETWEEN ONSET AND DEATH 2hr			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour o. p.m. p. m.	Month 19	Doy While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from 1935 , 19 1956 , to 16 April, 1956 , that I last saw the deceased alive on 15 April, 1956 , and that death occurred at 8:50 P.M. from the causes and on the date stated above.				ADDRESS (Street, city or town, state)		DATE SIGNED 4.16.56			
ACTUAL SIGNATURE <i>Wm. H. Lawson, Jr.</i>	M.D.		Liberty Road at Eldersburg						
PHYSICIAN'S NAME (Type) Wm. H. Lawson, Jr. M.D.			Sykesville, Maryland						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4-22-56	22c. NAME OF CEMETERY OR CREMATORIUM West Liberty		22d. LOCATION (City, town, or county) Alpha, Md		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE F.C. Higinbotham, Ellicott City, Md		ADDRESS		24a. REC'D BY REGISTRAR DATE 4-19-56		24b. REGISTRAR'S SIGNATURE C. Harry Ween			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it may be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

APR 23 1956

REGELY ED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3877

CERTIFICATE OF DEATH

03852

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after the deceased has been removed from the hospital or attending physician's office. After this certificate has been signed by the attending physician and completely filled in, it may be retained by the hospital or attending physician. **TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician, it should be detached for use as the burial-trust permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Carroll		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Sykesville		c. LENGTH OF STAY IN lb 11Y 2M 16 D		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		d. STREET ADDRESS 712 Gladstone Avenue	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First LUCIA	Middle	Lost DAVIS	4. DATE OF DEATH	Month 4	Day 5	Year 1956
5. SEX Female	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH 9/7/80	9. AGE (In years lost birthday) 75 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Hours 0	IF UNDER 24 HRS. Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher & Social Worker		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Philadelphia, Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Caleb S. Davis		14. MOTHER'S MAIDEN NAME Mary E. Blackman					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. unknown		17. INFORMANT Record, Springfield State Hospital		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease						INTERVAL BETWEEN ONSET AND DEATH years	
420.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. b.		DUE TO					
{ DUE TO c.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Secondary Anemia; Schizophrenic reaction, paranoid type						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Day	20d. INJURY OCCURRED White at work <input type="checkbox"/> Nat white at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Sykesville	(County) Md.	(State) Md.
21. I certify that I attended the deceased from 12/16 , 19 55 , to 4/5 , 19 56 , that I last saw the deceased alive on 4/1 , 19 56 , and that death occurred at 3:00 AM, from the causes and on the date stated above.				ADDRESS (Street, city or town, state) Sykesville, Maryland		DATE SIGNED 4/5/56	
ACTUAL SIGNATURE <i>Edmund Lusthaus</i>	PHYSICIAN'S NAME (Type) Edmund Lusthaus, M. D.						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Apr. 7, 1956	22c. NAME OF CEMETERY OR CREMATORIUM Parkwood Cemetery	22d. LOCATION (City, town, or county) Baltimore Co Md.	(State)			
23. FUNERAL DIRECTOR'S SIGNATURE HENRY SANDER & SONS, INC.		ADDRESS <i>George F. Sander</i>	24a. REC'D BY REGISTRAR George F. Sander	24b. REGISTRAR'S SIGNATURE <i>C. Harry Key</i>			
VS A15 (4) 15M 9/55			DATE Apr. 9, 1956				

81. ЗНОВИТЬ ВІДДАЧУ ВІД ПІДСІЧНОГО СТАРІНКА

BUREAU V. S.
APR 9 1956
REGELVÉU

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03853

3878

CERTIFICATE OF DEATH

Reg. Dist. No.

74

1. PLACE OF DEATH

a. COUNTY

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

c. LENGTH OF STAY IN 1b
Rural - Marriottsville

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE

Md

b. COUNTY

Carroll

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

d. STREET ADDRESS

Rural - Marriottsville

e. IS RESIDENCE ON A FARM?

YES NO 3. NAME OF DECEASED
(Type or print)

First

Middle

Last

4. DATE OF DEATH

Month

Day

Year

5. SEX

Hilda Susan Day

6. COLOR OR RACE

F. W.

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

Nov. 29, 1902

9. AGE (In years
from birthday)
53 yrs.10. IF UNDER 1 YEAR
Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10b. KIND OF BUSINESS OR INDUSTRY

Our Home

11. BIRTHPLACE (State or foreign country)

Md

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Edward Shirley

14. MOTHER'S MAIDEN NAME

Ellie Kathryn Bowman

Address

15. WAS DECEASED EVER IN U. S. ARMED FORCES?

(Yes, no, or unknown)

(If yes, give war or dates of service)

Me

16. SOCIAL SECURITY NO.

- - -

17. INFORMANT

Alice M. Lawrence T. Day Jr. Marriottsville, Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

443X

DUE TO

Cerebral Hemorrhage, rt. middle meningeal artery.

INTERVAL BETWEEN
ONSET AND DEATHConditions, if any, which
gave rise to immediate
cause (a), stating the under-
lying cause lost.

(b)

DUE TO

hypertensive cardiovascular disease

24 hrs

(c)

general arteriosclerosis

15 yrs.

15 yrs.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED?

YES NO

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour o.m.
p.m.20d. INJURY OCCURRED
While
at work Not while
at work 20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I attended the deceased from 1935, 19, to 10 April 1956, that I last saw the deceased alive on 10 April 1956, and that death occurred at 8:00 PM, from the causes and on the date stated above.

ADDRESS (Street, city or town, state)

DATE SIGNED

ACTUAL
SIGNATURE

M.D. Liberty Road at Eldersburg

4-12-56

PHYSICIAN'S
NAME (Type)

Wm. H. Lawson, Jr. M.D.

Sykesville P.O., Maryland

22a. BURIAL, CREMATION,
REMOVAL (Specify)

Burial

22b. DATE THEREOF

4-13-56

22c. NAME OF CEMETERY OR CEMPTORY

Springfield

22d. LOCATION (City, town, or county)

Oxon Hill, Md.

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

Hilda H. Height - Eldersburg, Md.

ADDRESS

Hilda H. Height - Eldersburg, Md.

24a. REC'D BY REGISTRAR

DATE 4-12-56

24b. REGISTRAR'S SIGNATURE

C. Harry Weir

STATE DEPARTMENT OF HEALTH - WISCONSIN

CERTIFICATE OF DEATH

RECEIVED
APR 17 1950

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3858

CERTIFICATE OF DEATH

03854

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY CARROLL		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WESTMINSTER		c. LENGTH OF STAY IN 1b 8 yrs		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 10 KEMPER AVE.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) CARRIE		First EMILY	Middle DERR	
4. DATE OF DEATH APRIL 30	Month 30	Day 1956	Year	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH NOV. 23, 1874	
9. AGE (In years lost birthday) 81	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) MD.	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME ALBERT T. FOWLER	14. MOTHER'S MAIDEN NAME ANNIE E. KELLY	Address 10 KEMPER AVE. WESTMINSTER, MD.		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO	16. SOCIAL SECURITY NO. R14-01-0498	17. INFORMANT THEODORE F. DERR	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442x DUE TO Cerebral Hemorrhage INTERVAL BETWEEN ONSET AND DEATH 4/27/56	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. { (b) DUE TO Hypertension & Cardio Renal Disease 10420 (c)				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)			
20c. TIME OF INJURY Hour a. m. p. m. 19	Month APRIL	Day 27	Year 1956	
20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) WESTMINSTER	(County) MD.	(State) MD.
21. I certify that I attended the deceased from april 27, 1956 , to april 30, 1956 , that I last saw the deceased alive on april 29, 1956 , and that death occurred at 12:56 P.M. from the causes and on the date stated above.				
ACTUAL SIGNATURE <i>Carrie E. Seichrist</i>	ADDRESS (Street, city or town, state) Westminster, Md.			DATE SIGNED 5/1/56
PHYSICIAN'S NAME (Type) H. Bentur & Son	22b. DATE THEREOF MAT 3, 1956			
22c. NAME OF CEMETERY OR CREMATORIUM WESTMINSTER CEM.	22d. LOCATION (City, town, or county) WESTMINSTER, MD.			
23. FUNERAL DIRECTOR'S SIGNATURE H. Bentur & Son	ADDRESS Westminster, Md.	24a. REC'D BY REGISTRAR DATE 5-2-56	24b. REGISTRAR'S SIGNATURE H. Bentur & Son	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-trust permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. S.

MAY 4 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3879

CERTIFICATE OF DEATH

03855
81

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY CARROLL MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY CARROLL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) UNION BRIDGE		c. LENGTH OF STAY IN 1b 6 MONTHS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION FARQUHAR ST.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) WILLIAM		First WALTER	Middle DONELSON
4. DATE OF DEATH APRIL		Last 8	Month Day Year 1956
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAR 9-1888
9. AGE (In years lost birthday) 68 yrs.		10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ENGINEER		10b. KIND OF BUSINESS OR INDUSTRY MAINTENANCE	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME ARTEMUS DONELSON		14. MOTHER'S MAIDEN NAME VIRGINIA BAUB LITZ	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 217-05-9862	
17. INFORMANT ARTEMUS DONELSON		Address BALTIMORE	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 33IX DUE TO Cerebral Hemorrhage Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO Arteriosclerosis (c)		INTERVAL BETWEEN ONSET AND DEATH 7 days	
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased alive on _____, 19_____, and that death occurred at _____, 19_____. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE J. H. Legg M.D. ADDRESS Union Bridge DATE SIGNED 7-8-56 PHYSICIAN'S NAME (Type) T. H. LEGG MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL APR 11-1956		22b. DATE THEREOF APR 11-1956	
22c. NAME OF CEMETERY OR CREMATORIAL BEAVER DAM		22d. LOCATION (City, town, or county) (State) FREDERICK Co. MD.	
23. FUNERAL DIRECTOR'S SIGNATURE P D HARTZLER & SONS		ADDRESS UNION BRIDGE MD	
24a. REC'D BY REGISTRAR DATE 4/10/56		24b. REGISTRAR'S SIGNATURE Leslie Reps	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after the funeral director may be retained by the physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

REGISTRATION

NUMBER

EXPIRATION

DATE

ISSUED

TO

NAME

ADDRESS

CITY

STATE

ZIP

PHONE

CITY

BUREAU V. S.

APR 12 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3880

CERTIFICATE OF DEATH

038566

Reg. Dist. No. 33

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE	
Carroll MARYLAND		Md.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Finksburg		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Hales Aged Home		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. STREET ADDRESS 4417 Belview Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First	Middle
		Frederick	Dorsey
		Ensor	Last
4. DATE OF DEATH		Month	Day
		April	24
		Year	1956
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
Male		White	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH		9. AGE (In years last birthday) 88 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.
Aug. 5, 1867		11. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired School Teacher		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME George Ensor		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Jos. Bublovack, 4417 Belview Ave. Balto.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) myocarditis - Chronic decompensatory 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arteriosclerosis - (general) years DUE TO (c) matted cerebral -		2 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4/22/56 to 4/24/56 , that I last saw the deceased alive on 4/22/56 , and that death occurred at 710 Reisterstown Rd , M., from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Reisterstown Md 4/25/56	
ACTUAL SIGNATURE James G. Saffell		DATE SIGNED 4/25/56	
PHYSICIAN'S NAME (Type) James G. Saffell M.D.		M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 27/56	
22c. NAME OF CEMETERY OR CREMATORIAL Druid Ridge		22d. LOCATION (City, town, or county) Pikesville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J.F. Eline & Sons, Reisterstown, Md.		24a. REC'D BY REGISTRAR DATE 4/25/56	
		24b. REGISTRAR'S SIGNATURE Harriet Miller	

DEPARTMENT OF STATE BUREAU OF INVESTIGATION
CELESTE DE BAPTISTE 538

BUREAU V. S.

APR 27 1956

REGELIV 30

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

03857

3881 CERTIFICATE OF DEATH

Reg. Dist. No. 75

1. PLACE OF DEATH

COUNTY

Canal

CITY (If outside corporate limits, write RURAL
OR and give nearest town)

TOWN

HOSPITAL OR
INSTITUTION OR
STREET ADDRESS

manchester

MARYLAND

LENGTH OF STAY
(in this place)

1 wk

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE

And

COUNTY

canal

CITY (If outside corporate limits, write RURAL and give nearest town)

TOWN

STREET
ADDRESSmanchester
(If rural give location)
127 W main st**3. NAME OF
DECEASED**(First)
(Type or Print)

(Middle)

(Last)

Bertie V. FOLK

4. DATE (Month) (Day) (Year)DATE
OF
DEATH4-30-56
19**5. SEX**

SEX

RACE

COLOR OR
RACE7. SINGLE, MARRIED,
WIDOWED, DIVORCED,
(Specify)

8. DATE OF BIRTH

9. AGE last birthday

IF UNDER 1 YEAR
Months Days Hours Min.10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if
retired)10b. KIND OF BUSINESS
OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT
COUNTRY?

13. FATHER'S NAME

George Falk

14. MOTHER'S MAIDEN NAME

Martha Larson

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unk.)

(If Yes, give war or dates of service)

no

16. SOCIAL SECURITY NO.

nan

17. INFORMANT & ADDRESS

Charles H Falk

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.0 IMMEDIATE CAUSE (A)
 ANTECEDENT CAUSE(S) DUE TO
 DISEASES OR CONDITIONS, IF ANY, (B)
 GIVING RISE TO THE ABOVE CAUSE DUE TO
 STATING UNDERLYING CAUSE LAST. (C)

18. MEDICAL CERTIFICATIONArteriosclerotic Heart Disease
with congestive heart failureINTERVAL BETWEEN
ONSET AND DEATH

5 yrs

Atelectasis of rt lower lobe of lung 3 wks

**II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING DEATH.**

19e. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES NO 21a. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF DEATH
(If either, NOTIFY MEDICAL EXAMINER)21b. PLACE (Home, farm, factory,
OF INJURY street, office bldg., etc.)

21c. WHERE DID INJURY OCCUR? (City or town)

(County)

(State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)

21e. INJURY OCCURRED
While
at work Not while
at work

21f. HOW DID INJURY OCCUR?

M.

M.

M.

22. I hereby certify that I attended the deceased from June 1948 to April 30 1956, that I last saw the deceased

alive on 4/30/1956, and that death occurred at 5:30 P.M. from the causes and on the date stated above.

SIGNATURE

W.H. Board

P.M. ADDRESS (Street, city, town, state)

DATE SIGNED

Manchester, Md. 4/30/56

23. BURIAL, CREMATION,
REMOVAL (SPECIFY)

DATE THEREOF

NAME OF CEMETERY OR CREMATORI

LOCATION (City, town, or county)

(State)

Burial

5-3-56

Linenfield Cemetery Canal Md

RECD BY REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

april 30 1956

M.W. Denner

Frederick B. Butler Hanover

DEPARTMENT OF STATE - WASHINGTON, D. C.

RECEIPT OF DATA

BUREAU V. S.

NY 2 1956

RECEIVED

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A1SC 1-5 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18**3882 CERTIFICATE OF DEATH**

03858

Reg. Dist. No.

78

1. PLACE OF DEATH			2. USUAL RESIDENCE (HOME) OF DECEASED		
COUNTY Carroll CITY (If outside corporate limits, write RURAL OR and give nearest town) rural-Westminster		MARYLAND LENGTH OF STAY (in this place) life		STATE Maryland COUNTY Carroll CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural --Westminster	
HOSPITAL OR INSTITUTION OR STREET ADDRESS			STREET ADDRESS (If rural give location) Taylorsville		
3. NAME OF DECEASED (Type or Print) CARRIE			4. DATE OF DEATH April 27 19 56		
5. SEX female	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) widowed	8. DATE OF BIRTH 2-10-1883	9. AGE last birthday 73 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife			10b. KIND OF BUSINESS OR INDUSTRY ----	11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Ezra Wantz			14. MOTHER'S MAIDEN NAME Belinda Brown		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) no		16. SOCIAL SECURITY NO. none		17. INFORMANT & ADDRESS Union Bridge Mrs. Belinda Pittinger, Md.	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 422.2 IMMEDIATE CAUSE (A) CHRONIC MYOCARDITIS ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, (B) FATTY DEGENERATION GIVING RISE TO THE ABOVE CAUSE DUE TO STATING UNDERLYING CAUSE LAST. (C) Sudden					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED M. While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Feb 10, 1956, to April 27, 1956, that I last saw the deceased alive on April 24, 1956, and that death occurred at 3 P.M. from the causes and on the date stated above.					
SIGNATURE T. H. Legg M.D. ADDRESS (Street, city, town, state) Union Bridge Md DATE SIGNED 4-28-56					
23. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		DATE THEREOF 4-30-1956		NAME OF CEMETERY OR CREMATORIUM Kriders LOCATION (City, town, or county) Westminster, Md. (State)	
24. REC'D BY REGISTRAR DATE April -30-56		REGISTRAR'S SIGNATURE E. M. Farmer		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS C. M. Waltz, Winfield, Md.	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03859

3883

CERTIFICATE OF DEATH

Reg. Dist. No. 82-83

1. PLACE OF DEATH a. COUNTY Carroll		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural-Mt. Airy		c. LENGTH OF STAY IN 1b 47 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural--Mt. Airy	
3. NAME OF DECEASED (Type or print) R. HARVEY GREEN		d. STREET ADDRESS Ridgeville	
4. DATE OF DEATH April 30, 1956		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 10-2-1885
9. AGE (In years lost/birthday) 70 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0	11. IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Grower		10b. KIND OF BUSINESS OR INDUSTRY Ridgeville Nurseries	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Alfred Green		14. MOTHER'S MAIDEN NAME Margaret McSherry	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 216-09-8476	
17. INFORMANT Mrs. Etta Green, Mt. Airy, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 14, 1956 , to Apr. 30, 1956 , that I last saw the deceased alive on Apr. 30, 1956 , and that death occurred at 1:30 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE C. M. Van Poole		ADDRESS (Street, city or town, state) Mt. Airy, Md.	
DATE SIGNED 4-30-56			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 5-3-1956	
22c. NAME OF CEMETERY PINE GROVE		22d. LOCATION (City, town, or county) (State) Mt. Airy, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE S. M. Waltz		24a. REC'D BY REGISTRAR DATE 5-3-56	
ADDRESS Winfield, Md.		24b. REGISTRAR'S SIGNATURE Robert R. Hurtt	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU Y.
RECEIVED
MAY 7 1956

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
3859 CERTIFICATE OF DEATH

03860
Reg. Dist. No. 26

1. PLACE OF DEATH a. COUNTY Carroll		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Carroll		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster		c. LENGTH OF STAY IN 1b 13 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster		d. STREET ADDRESS 63 Liberty St.		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 63 Liberty St.				d. STREET ADDRESS 63 Liberty St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) CARRIE ELIZABETH GRIMES		First CARRIE	Middle ELIZABETH	Last GRIMES	4. DATE OF DEATH April 4, 1956	Month April	Day 4	Year 1956
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH 1-18-1877	9. AGE (In years last birthday) 79 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Hours	Min. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME Alfred Linton		14. MOTHER'S MAIDEN NAME Dora Frost						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Miss Esther Grimes,		Address same as above		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		<i>Cardiovascular/Renal disease</i>				INTERVAL BETWEEN ONSET AND DEATH 2 yrs		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c) DUE TO		<i>Hypertension & arteriosclerosis</i>				5 yrs		
		<i>Diabetes mellitus</i>				10-15 yrs		
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>march</u> , 1953 to <u>April 4</u> , 1956, that I last saw the deceased alive on <u>April 4</u> , 1956, and that death occurred at <u>10:30 P.M.</u> from the causes and on the date stated above.								
ACTUAL SIGNATURE <i>W. Glenn Speicher, M.D.</i>				ADDRESS (Street, city or town, state) <i>Westminster Md.</i>		DATE SIGNED <i>April 5-1956</i>		
PHYSICIAN'S NAME (Type) W. Glenn Speicher								
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 4-7-1956		22c. NAME OF CEMETERY OR CREMATORIAL Bethesda		22d. LOCATION (City, town, or county) Carroll Co., Maryland		(State)
23. FUNERAL DIRECTOR'S SIGNATURE <i>G. M. Waitz</i>		ADDRESS Winfield, Md.		24a. REC'D BY REGISTRAR 4-7-17		24b. REGISTRAR'S SIGNATURE <i>Harriet Miller</i>		

CERTIFICATE OF DEATH

FEDERAL BUREAU OF INVESTIGATION

APR 10 1956

RECEIVED

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS MSC 155 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

03861

3884 CERTIFICATE OF DEATH

Reg. Dist. No. 50

1. PLACE OF DEATH CITY TOWN HOSPITAL OR INSTITUTION OR STREET ADDRESS		New Windsor New Windsor New Windsor Leje		2. USUAL RESIDENCE (HOME) OF DECEASED STATE CITY TOWN STREET ADDRESS		Md in New Castle Md in New Castle New Windsor P.D. 2	
3. NAME OF DECEASED (Type or Print)		(First) (Middle) (Last) EFFIE Louise HAINES		4. DATE OF DEATH		Apr 24 1956	
5. SEX F	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	M	8. DATE OF BIRTH 7-19-1868	9. AGE last birthday 87 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Samuel Diehl		14. MOTHER'S MAIDEN NAME Sarah Ann Haines		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS Archer Haines		18. MEDICAL CERTIFICATION Arterio Sclerotic Cardiovascular disease years		19. DATE OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 1946 to Apr 24, 1956, that I last saw the deceased alive on Apr 20, 1956, and that death occurred at 7A.M. from the causes and on the date stated above. SIGNATURE James J. Marsh ADDRESS (Street, city, town, state) M.D. Winstowter Md DATE SIGNED Apr 25/56							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		DATE THEREOF 4-27-56 PIPE CREEP GEM UNION TOWN		NAME OF CEMETERY OR CREMATORIUM PIPE CREEP GEM UNION TOWN		LOCATION (City, town, or county) Westminster Md (State)	
24. REC'D BY REGISTRAR DATE Apr 26/56		REGISTRAR'S SIGNATURE Euseb Bredel		25. FUNERAL DIRECTOR'S SIGNATURE K. BARKER R.D. 5 WESTMINSTER		ADDRESS	

BY IRON MOUNTAIN TO THE DEPARTMENT OF STATE

CHIEF STAFF OF THE UNITED STATES GOVERNMENT

BUREAU U. S.

APR 30 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7, Film G195 1-16-56 et

03862

3885

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 25 yrs. 11 mos.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Mazie	Middle ---	Last Halligan
4. DATE OF DEATH	Month 4	Day 4	Year 1956
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> Unknown	8. DATE OF BIRTH Unknown
9. AGE (In years last birthday) 85 (?) yrs.	10. IF UNDER 1 YEAR Months —	11. IF UNDER 24 HRS. Days —	12. IF UNDER 24 HRS. Hours —
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laundress	10b. KIND OF BUSINESS OR INDUSTRY ---	11. BIRTHPLACE (State or foreign country) Not known	12. CITIZEN OF WHAT COUNTRY? U.S.A. (?)
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) ---		16. SOCIAL SECURITY NO. ---	
17. INFORMANT Address Hospital records - Springfield Hosp.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic neoplastic disease DUE TO 170X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) Primary carcinoma of left breast DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Epilepsy with mental deficiency	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 3 yrs. plus	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ---	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. --- 19	20d. INJURY OCCURRED White Not white of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ---	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 4-30 , 19 30 , to 4-4 , 19 56 , that I last saw the deceased alive on 4-4 , 19 56 , and that death occurred at 8:30 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE M. N. Mastin	M.D.	ADDRESS (Street, city or town, state) Sykesville Md	
PHYSICIAN'S NAME (Type) Morrell N. Mastin, M.D.	DATE SIGNED April 4, 1956		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4/6/56	22c. NAME OF CEMETERY OR CREMATORIAL Acrel Forest	22d. LOCATION (City, town, or county) (State) Germantown Rd
23. FUNERAL DIRECTOR'S SIGNATURE J. J. Tolson & Sons 1318 Light St. P.R. 9 1956		24a. REC'D. BY REGISTRAR DATE C. Harry New	24b. REGISTRAR'S SIGNATURE

CERTIFICATE OF DEATH

BUREAU V. S.

APR 9 1956

RECEIVED

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

03863

Reg. Dist. No.

94

O DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 3 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

O FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Sykesville			2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md. b. COUNTY Carroll c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		
c. LENGTH OF STAY IN 1b 20 years			d. STREET ADDRESS		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) CHARLES E HARRISON		First	Middle	Last	4. DATE OF DEATH Month April Day 7 Year 1956
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 29 1891	9. AGE (In years last birthday) 64 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chauffeur		10b. KIND OF BUSINESS OR INDUSTRY car		11. BIRTHPLACE (State or foreign country) Md.	
13. FATHER'S NAME James T. Harrison		14. MOTHER'S MAIDEN NAME Elizabeth Shorts		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Wife - Mr. James Harrison - Wife		17. INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CRUSHING INJURY TO CHEST DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause lost. DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. AUTOMOBILE Accident					
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Route 32		20c. TIME OF INJURY Month, Day, Year Hour 6 15 p.m. Date 4-7 1956		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Route 32		20f. (City or town) Sykesville, Carroll Md.		(County) Carroll (State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE James T. Marsh		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 4/7/56	
EXAMINER'S NAME (Type) JAMES T. MARSH		22d. LOCATION (City, town, or county) Howard Co. Md. (State) Md.			
22e. BURIAL, CREMATION, OR CRYONIC (Specify) Burial		22f. DATE THEREOF 4-10-56		22g. NAME OF CEMETERY OR CREMATORIUM Jennings Chapel	
23. FUNERAL DIRECTOR'S SIGNATURE Elton H. Height, Sykesville, Md.		ADDRESS Jennings Chapel, Sykesville, Md.		24a. REC'D BY REGISTRAR C. Harry Lee DATE 4-9-56 24b. REGISTRAR'S SIGNATURE C. Harry Lee	

3800 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

APR 13 1956

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, using the word "pending", in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial; cremation, or removal.

VS. AISM(E)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 3887 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03864
74

Reg. Dist. No.

Item 9. Film G196 L-23-56 et

1. PLACE OF DEATH a. COUNTY Carroll		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Sykesville		c. LENGTH OF STAY IN 1b 13Y 0M 11 D		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		d. STREET ADDRESS 1731 E. Pratt Street			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) ALBERT CHARLES HARTMEYER		First	Middle	Last	4. DATE OF DEATH 4 11 1956	Month	Day	Year	
S. SEX Male	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 9/2/03	9. AGE (In years last birthday) 52 56 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plumber's helper		10b. KIND OF BUSINESS OR INDUSTRY Plumbing		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Albert Hartmeyer		14. MOTHER'S MAIDEN NAME Louise Bunger							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Record, Springfield State Hospital		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Myocardial infarct		INTERVAL BETWEEN ONSET AND DEATH instant					
420.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		(b) Arteriosclerotic heart disease		years					
DUE TO (b)									
DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		Schizophrenic reaction, paranoid type		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour o. m. p. m.		Month, Day, Year 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Baltimore		(County) Md.	(State) Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .									
ACTUAL SIGNATURE <i>James T. Marsh</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <i>4/12/56</i>					
EXAMINER'S NAME (Type) James T. Marsh, M. D.									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Apr. 13. 1956		22c. NAME OF CEMETERY OR CREMATORIUM Baltimore Cem.		22d. LOCATION (City, town, or county) Baltimore Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE HENRY SANDER & SONS, INC. Baltimore Md.		ADDRESS <i>Key T. Sander</i>		24a. REC'D. BY REGISTRAR APR 16 1956		24b. REGISTRAR'S SIGNATURE <i>Henry Sander</i>			

MISSOURI STATE DEPARTMENT OF HEALTH—A DIVISION OF
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

APR 16 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
3888 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

0386574
 Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, using the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY Carroll		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Sykesville		c. LENGTH OF STAY IN lb 6 yrs. 8 months	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 15 Springfield State Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City	
d. STREET ADDRESS 2453 Barclay Street		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF -DECEASED (Type or print)	First FRANK	Middle FERNAND	Last HECKMAN
4. DATE OF DEATH April	Month 12	Day 19	Year 56
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 12-24-02
9. AGE (In years last birthday) 53 yrs.	10. KIND OF BUSINESS OR INDUSTRY Carpenter	11. BIRTHPLACE (State or foreign country) Kentucky	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME William J. Heckman		14. MOTHER'S MAIDEN NAME Emma Norman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 17. INFORMANT Springfield State Hospital - Sykesville, Md.	
Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction			
DUE TO 420.1			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Thrombosis			
DUE TO 420.1			
(c) Pulmonary Edema			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
Psychosis with chronic alcoholism, paranoid type.			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Patient was found dead face down in creek.	
20c. TIME OF INJURY Hour a. m. 4-12		Month, Day, Year p. m. 19 56	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Hospital		20f. (City or town) Sykesville	(County) Carroll (State) Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>James T. Marsh</i>	DATE SIGNED 4/12/57		
EXAMINER'S NAME (Type) James T. Marsh	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 4-16-56	22c. NAME OF CEMETERY OR CREMATORIUM St. Peters	22d. LOCATION (City, town, or county) BALTO. Md.
23. FUNERAL DIRECTOR'S SIGNATURE Willig W. Cook Inc 1511 St Paul St	ADDRESS DATE APR 17	24a. REC'D BY REGISTRAR C. Harry Keay	24b. REGISTRAR'S SIGNATURE

APR 17 1956

DECEMBER

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03866

3889 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

74

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, striking the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)
SM 9/55

1. PLACE OF DEATH a. COUNTY Carroll		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Sykesville		c. LENGTH OF STAY IN 1b 1Y 4M 7 D	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
f. STREET ADDRESS 3616 Ash Street		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Fannie		First Fannie	Middle Leah
4. DATE OF DEATH HINES		Month 4	Day 25
5. SEX Female		6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH 5/25/00
9. AGE (In years last birthday) 55 yrs.		10. IF UNDER 1 YEAR Months 55	11. IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME ?		14. MOTHER'S MAIDEN NAME ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) -		16. SOCIAL SECURITY NO. -	
17. INFORMANT Record, Springfield State Hospital		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 420.1 (b) Coronary artery thrombosis DUE TO (c) Arteriosclerosis of coronary artery INTERVAL BETWEEN ONSET AND DEATH instantaneous			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Fracture of right hip Chronic brain syndrome assoc. with convulsive disorder with psychosis			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Patient fell to floor on ward	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 4/17 19 56		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) hospital	
20f. (City or town) Sykesville		(County) Carroll	
		(State) Maryland	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE James T. Marsh		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) James T. Marsh, M. D.		DATE SIGNED 4/26/56	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 4/28/56	
22c. NAME OF CEMETERY OR CREMATORIAL ST MARYS		22d. LOCATION (City, town, or county) HAMPDEN	
23. FUNERAL DIRECTOR'S SIGNATURE Paul E. Schenck		ADDRESS 3015-17 Chestnut Ave	
		24a. REG'D BY REGISTRAR DATE APR 27 1956	
		24b. REGISTRAR'S SIGNATURE C. Harry Keer	

BUREAU Y. S.

MAY I 1956

THE GENEVE EDITION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3890

CERTIFICATE OF DEATH

03867
76

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY CARROLL		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE M.D.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural WESTMINSTER		c. LENGTH OF STAY IN 1b 84 yrs.		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 131 LIBERTY ST.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural WESTMINSTER		
d. STREET ADDRESS 131 LIBERTY ST.		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) JACOB	First	Middle	Last	
4. DATE OF DEATH APRIL 5 1956	Month	Day	Year	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEB. 20 1872	
9. AGE (In years lost birthday) 84 yrs.	10. IF UNDER 1 YEAR Months 1	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RET. CONTRACTOR+BUILDER	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) MD.	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John W. HOLMES	14. MOTHER'S MAIDEN NAME MARY V. STEVENSON			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO	16. SOCIAL SECURITY NO. 216-03-5945	17. INFORMANT (Mrs) Ruth Garbaugh	Address 131 LIBERTY ST. WESTMINSTER, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremic coma DUE TO 450.0		INTERVAL BETWEEN ONSET AND DEATH 2 days		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arterio sclerosis (generalized) DUE TO (c) Senility		5 years		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) —		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) MD.	20f. (City or town) Westminster	(County) MD.
21. I certify that I attended the deceased from april 1st, 1956 , to apr. 5, 1956 , that I last saw the deceased alive on apr. 5th, 1956 , and that death occurred at 230 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Westminster, Md. 21151				
ACTUAL SIGNATURE C. T. Billingslea	DATE SIGNED 4-12-56			
PHYSICIAN'S NAME (Type) C. L. Billingslea				
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 4-8-1956	22c. NAME OF CEMETERY OR CREMATORIAL DEEP PARK CEM.	22d. LOCATION (City, town, or county) SMALLWOOD	(State) MD.
23. FUNERAL DIRECTOR'S SIGNATURE H. BANKARD + SON	ADDRESS WESTMINSTER MD.	24a. REC'D BY REGISTRAR DATE 4-12-56	24b. REGISTRAR'S SIGNATURE Harold Muller	

RECEIVED - BUREAU OF INVESTIGATION - CALIFORNIA STATE POLICE DEPARTMENT

CERTIFICATE OF DESIGN

RECEIVED

BUREAU V. S.

APR 16 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3860

CERTIFICATE OF DEATH

03868
27

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY CARROLL		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE M.D.		b. COUNTY CARROLL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WESTMINSTER		c. LENGTH OF STAY IN 1b 16 TBS.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WESTMINSTER		d. STREET ADDRESS 174 W. MAIN	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 174 W. MAIN				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First JOHN	Middle WILLIAM	Last HULL	4. DATE OF DEATH APRIL 10 1956	Month Day Year		
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCTOBER 25 1875	9. AGE (In years lost birthday) 80 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WATCHMAKER		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME CYRUS HULL		14. MOTHER'S MAIDEN NAME CAROLINE LEISTER		Address 174 W. MAIN, WESTMINSTER MD.			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 018-32-1193		17. INFORMANT CARRIE SMITH HULL, WESTMINSTER MD.		INTERVAL BETWEEN ONSET AND DEATH 24 mos	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and, (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442x		Cardiac decompensation					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)		Cerebral Hemorrhage				3 mos	
DUE TO (c)		Cardio renal Vasculitis				2 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 2 1957 to Apr 10 1957 that I last saw the deceased alive on Apr 9 1956 , and that death occurred at 6 A.M. from the causes and on the date stated above.				ADDRESS (Street, city or town, state) M.D. Westminster Md.		DATE SIGNED 4-12-56	
ACTUAL SIGNATURE Thomas R. Fritz							
PHYSICIAN'S NAME (Type) Thomas R. Fritz							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-13-1956		22c. NAME OF CEMETERY OR CREMATORIUM MEADOWBRANCH Cemetery		22d. LOCATION (City, town, or county) WESTMINSTER MD. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE H. Brinkley		ADDRESS Brinkley's Body WESTMINSTER MD.		24a. REC'D BY REGISTRAR DATE 4-14-56		24b. REGISTRAR'S SIGNATURE Harriet Rubin	

CERTIFICATE OF DEATH

BUREAU V. S.
RECEIVED
APR 17 1956

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03869
74

3891 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Sykesville		c. LENGTH OF STAY IN 1b 13Y 8 M 23D		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		d. STREET ADDRESS Formerly of 1905 N. Fulton Avenue RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				d. STREET ADDRESS 431 Wellington Avenue				
3. NAME OF DECEASED (Type or print)	First Emma	Middle Veoria	Last JACKSON	4. DATE OF DEATH	Month 4	Day 30	Year 56	
5. SEX Female	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 11/12/73	9. AGE (In years last birthday) 82 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Corwine			14. MOTHER'S MAIDEN NAME --					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. unknown		17. INFORMANT Record, Springfield State Hospital		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic nephritis 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Chronic hypertensive cardiovascular disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Chronic brain syndrome assoc. with cerebral arteriosclerosis with psychosis								INTERVAL BETWEEN ONSET AND DEATH month
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)								19. WAS AUTOPSY PERFORMED? <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Day	Year	20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from 3/28 , 19 56 , to 4/30 , 19 56 , that I last saw the deceased alive on 4/29 , 19 56 , and that death occurred at 11:15 AM DST, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Sykesville, Maryland DATE SIGNED 4/30/56								
ACTUAL SIGNATURE Edmund Lusthaus M.D. PHYSICIAN'S NAME (Type) Edmund Lusthaus, M. D.								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 5/2/56	22c. NAME OF CEMETERY OR CREMATORIUM Holy Redeemer Cem.			22d. LOCATION (City, town, or county) Balto., Md.			
23. FUNERAL DIRECTOR'S SIGNATURE John J. Pickner & Sons - Balt 17, Md.	ADDRESS				24a. REC'D BY REGISTRAR DATE 5/2/56	24b. REGISTRAR'S SIGNATURE C. Harry Steers		

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03870

3892

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH a. COUNTY Carroll		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Pennsylvania		b. COUNTY 75X-3	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 16 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Philadelphia			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		d. STREET ADDRESS 536 Girard Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First John	Middle -	Lost	4. DATE OF DEATH April	Month	Day 28	Year 19 56
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH July 1894	9. AGE (In years lost birthday) 61 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) seaman		10b. KIND OF BUSINESS OR INDUSTRY unk -		11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Johnson		14. MOTHER'S MAIDEN NAME Elyanow		-		?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unk		16. SOCIAL SECURITY NO. unk		17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchogenic Carcinoma with cerebral metastases 162X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 3 months plus							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) C.B.S. assoc. with diseases of unknown or uncertain causes with psych. 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) reaction					
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Day	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Phila, Pa.	(County)	(State)
21. I certify that I attended the deceased from 4-14-56 , 19 56 , to 4-28-56 , 19 56 , that I last saw the deceased alive on 4-27-56 , 19 56 , and that death occurred at 8:25 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Sykesville, Md. DATE SIGNED 1-28-56							
ACTUAL SIGNATURE Edmund Lusthaus	PHYSICIAN'S NAME (Type) Edmund Lusthaus						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 5/2/56	22c. NAME OF CEMETERY OR CREMATORIUM Holy Cross			22d. LOCATION (City, town, or county) Phila, Pa. (State)		
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook, Inc. 1217 N. Highland St.		ADDRESS 1217 N. Highland St.		24a. REC'D BY REGISTRAR DATE 4/28/56		24b. REGISTRAR'S SIGNATURE C. Harry Zeller	

BUREAU V. S.

1956 2 May

DECEMBER

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03871
74

3893

CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Carroll		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 9 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore (14)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				d. STREET ADDRESS 4703 Catalpha Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First JOHN	Middle GEORGE	Last KIRCHNER	4. DATE OF DEATH April	Month Day Year 13 19 56
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH June 14, 1872	9. AGE (In years lost birthday) 83 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stationary Engineer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Pennsylvania	
13. FATHER'S NAME Jacob Kirchner		14. MOTHER'S MAIDEN NAME Anna		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Springfield State Hospital - Sykesville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease				INTERVAL BETWEEN ONSET AND DEATH Years	
420.0 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) Generalized Arteriosclerosis				Years	
DUE TO					
DUE TO					
(c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) CBS associated with cerebral arteriosclerosis, with psychotic reaction.				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	Day	20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 4-11 , 1956, to 4-13 , 1956, that I last saw the deceased alive on 4-13 , 1956, and that death occurred at 2:45 P.M. from the causes and on the date stated above.				ADDRESS (Street, city or town, state) Springfield State Hospital	
ACTUAL SIGNATURE <i>Agustín del Campo</i>				DATE SIGNED 4-13-56	
PHYSICIAN'S NAME (Type) Agustín del Campo, M. D.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/16.1956n		22c. NAME OF CEMETERY OR CREMATORIUM Parkwood Cemetery	
22d. LOCATION (City, town, or county) Baltimore, Maryland					
23. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck, 5305 Harford Road #14		ADDRESS		24a. REC'D BY REGISTRAR APR 17 1956	24b. REGISTRAR'S SIGNATURE <i>C. Harry New</i>

DEPARTMENT OF HOMELAND SECURITY
CERTIFICATE OF DEATH

DEATH DATE	APRIL 17, 1956	DEATH TIME	10:00 AM
DEATH PLACE	EDWARD R. MURROW STUDIO WNET-TV CHANNEL 13 125 WEST 65TH STREET NEW YORK CITY	CAUSE OF DEATH	HEART ATTACK
AGE AT DEATH	64	SEX	MALE
NAME	EDWARD R. MURROW		
ADDRESS	125 WEST 65TH STREET NEW YORK CITY		
PHONE NUMBER	212-586-1234		
DEATH CERTIFICATE NUMBER	1234567890		
ISSUED BY	DEPARTMENT OF HOMELAND SECURITY		
ISSUED ON	APRIL 17, 1956		
ISSUED BY SIGNATURE	EDWARD R. MURROW		
RECEIVED BY	DEPARTMENT OF HOMELAND SECURITY		
RECEIVED ON	APRIL 17, 1956		
RECEIVED BY SIGNATURE	EDWARD R. MURROW		

APR 17 1956

RECEIVED
DEPARTMENT OF HOMELAND SECURITY

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3894

CERTIFICATE OF DEATH

Reg. Dist. No.

103872

1. PLACE OF DEATH a. COUNTY CARROLL		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD.		b. COUNTY CARROLL						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL WESTMINSTER		c. LENGTH OF STAY IN lb 84 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL WESTMINSTER		d. STREET ADDRESS BOND ST. EXT.						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION BOND ST. EXT.				d. STREET ADDRESS BOND ST. EXT.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) CHARLES		First LEPOY	Middle LEPO	Lost LEPO	4. DATE OF DEATH APRIL 8 1956	Month 8	Day Year 1956					
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MARCH 2, 1910		9. AGE (In years lost, birthday) 46 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TRACT DRIVER		10b. KIND OF BUSINESS OR INDUSTRY LUMBER		11. BIRTHPLACE (State or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.						
13. FATHER'S NAME PERCY L. LEPO				14. MOTHER'S MAIDEN NAME ETTA JONES								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 217-03-5299		17. INFORMANT SARAH LEPO		Address BONI ST. EXT. WESTMINSTER, MD.						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1		DUE TO Coronary Thrombosis		INTERVAL BETWEEN ONSET AND DEATH 1/2 hr								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)		DUE TO Coronary Sclerosis & —		(54 months) 1954-1955								
(c)		Coronary Thrombosis										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)										
20c. TIME OF INJURY Month, Doy, Year Hour o. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) WESTMINSTER		(County) MD.		(State) MD.		
21. I certify that I attended the deceased from april 16, 1956 to april 8, 1956 that I last saw the deceased alive on april 8, 1956 , and that death occurred at 4:00 AM , from the causes and on the date stated above.											ADDRESS (Street, city or town, state) Westminster, Md.	DATE SIGNED April 16, 1956
ACTUAL SIGNATURE W. Gleason Speicher, M.D.												
PHYSICIAN'S NAME (Type)												
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF APR. 11-1956		22c. NAME OF CEMETERY OR CREMATORIUM RIDERS REF. CEM. WESTMINSTER		22d. LOCATION (City, town, or county) WESTMINSTER MD.		(State) MD.				
23. FUNERAL DIRECTOR'S SIGNATURE H. Bankard Son Westminster, Md.		ADDRESS		24a. REC'D BY REGISTRAR 4-12-56		24b. REGISTRAR'S SIGNATURE Horace Mullin						

CERTIFICATE OF CECIEN

BUREAU Y. S.

APR 16 1956

RECEIVED

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 155-10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

3895

CERTIFICATE OF DEATH

03873

71

Reg. Dist. No.

1. PLACE OF DEATHCOUNTY *Carroll*

MARYLAND

CITY (If outside corporate limits, write RURAL
OR give nearest town)

TOWN

*Sykesville*LENGTH OF STAY
(in this place)*8 y 7 mos.*HOSPITAL
INSTITUTION OR
STREET ADDRESS**2. USUAL RESIDENCE (HOME) OF DECEASED**STATE *Maryland*COUNTY *Carroll*

CITY (If outside corporate limits, write RURAL and give nearest town)

TOWN

Sykesville

(If rural give location)

STREET
ADDRESS**3. NAME OF
DECEASED**

(Type or Print)

(First) *Simon*

(Middle)

(Last)

*May***4. DATE
OF
DEATH**(Month) *4* (Day) *11* (Year) *19 56*5. SEX *male*6. COLOR OR
RACE *white*7. SINGLE, MARRIED,
WIDOWED, DIVORCED.
(Specify) *widowed*8. DATE OF BIRTH
*Nov 27 1874*9. AGE last birthday
*81 yrs.*IF UNDER 1 YEAR
Months *0* Deys *0* Hours *0* Min. *0*10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if
retired) *Merchant*10b. KIND OF BUSINESS
OR INDUSTRY *Schaeff-Iron*11. BIRTHPLACE (State or foreign country) *Darmstadt Germany*12. CITIZEN OF WHAT
COUNTRY? *Germany*13. FATHER'S NAME *Hippoman*(First) *May*14. MOTHER'S MAIDEN NAME *Caroline*15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unk.) *No* (If Yes, give war or dates of service)16. SOCIAL SECURITY NO. *none*17. INFORMANT & ADDRESS *Dr. Sertind Gross, daughter*INTERVAL BETWEEN
ONSET AND DEATH*2 hrs***I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH**

IMMEDIATE CAUSE (A)

ANTECEDENT CAUSE(S) DUE TO

DISEASES OR CONDITIONS, IF ANY,
GIVING RISE TO THE ABOVE CAUSE
STATING UNDERLYING CAUSE LAST. (B)

DUE TO

(C)

*Coronary occlusion**Generalized arteriosclerosis**years***II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING DEATH.**

19e. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES NO 21e. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)21b. PLACE (Home, farm, factory,
street, office bldg., etc.)

21c. WHERE DID INJURY OCCUR? (City or town)

(County)

(State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)

21e. INJURY OCCURRED

21f. HOW DID INJURY OCCUR?

M. While at work Not while at work

22. I hereby certify that I attended the deceased from

April 11, 1956, to *April 11, 1956*, that I last saw the deceased alive on *April 11, 1956*, and that death occurred at *11:50 AM*, from the causes and on the date stated above.

SIGNATURE

Walter St. Sonnenfeldt

M.D.

ADDRESS (Street, city, town, state)

DATE SIGNED *4/12/56*23. BURIAL, CREMATION,
REMOVAL (SPECIFY) *Burial*DATE THEREOF *4-13-56*NAME OF CEMETERY OR CREMATORIUM *Rosedale*LOCATION (City, town, or county) *Baltimore*(State) *Md*

24. REC'D BY REGISTRAR

REGISTRAR'S SIGNATURE *Harry Stees*25. FUNERAL DIRECTOR'S SIGNATURE *Jack Lewis Inc 2100 Eastern Bl*

ADDRESS

DATE *4/13/56*

WISCONSIN STATE DEPARTMENT OF MARINE-FARWATER

CERTIFICATE OF DEATH

BUREAU V. S.

APR 13 1956

REGISTRY

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 155-10A

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

03874

CERTIFICATE OF DEATH

3896

Reg. Dist. No. 75

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN	Carroll Manchester	MARYLAND LENGTH OF STAY (in this place)	STATE Maryland CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Manchester
HOSPITAL OR INSTITUTION OR STREET ADDRESS	Ferrier Road	STREET ADDRESS	(If rural give location) Ferrier Road
3. NAME OF DECEASED (Type or Print)	Mrs. (First) Grace E. (Middle) Mc Adow (Last) Mrs. Estella G. Mc Adow	4. DATE OF DEATH 4/27/ 19 56	
SEX female	COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) widowed	B. DATE OF BIRTH Oct. 3, 1877
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday 78 yrs.
13. FATHER'S NAME Adam Snyder		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS Manchester, Maryland Mrs. Howard Bowling, Ferrier Rd.
18. MEDICAL CERTIFICATION I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH IMMEDIATE CAUSE (A) ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, (B) GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 6 Months	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Hypertension		3 yrs	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, street, office bldg., etc.)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from.....Nov. 23, 19 54.....to.....April 127 ¹⁹ 56....., that I last saw the deceased alive on.....April 26 19 56....., and that death occurred at 10.30 P.M. from the causes and on the date stated above. 4/27/56 SIGNATURE W.H. Board M.D. ADDRESS (Street, city, town, state) DATE SIGNED			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	DATE THEREOF 5/1/1956	NAME OF CEMETERY OR CREMATORIUM Baltimore Cemetery	LOCATION (City, town, or county), Md. (State) Baltimore, Maryland
24. REC'D BY REGISTRAR DATE 5/2/56	REGISTRAR'S SIGNATURE Mrs. H. H. Dennis	25. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck, 5305 Marford Road #14	

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

3897

03875

Reg. Dist. No.

76

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, using the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial or removal.

1. PLACE OF DEATH a. COUNTY CARROLL		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE MARYLAND b. COUNTY CARROLL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL WESTMINSTER		c. LENGTH OF STAY IN 1b 46 yrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) BACHMAN'S VALLEY (SULLIVAN RD.)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL WESTMINSTER RD#2	
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH ESTHER ELIZABETH MILLER	
First FEMALE		Middle WHITE	Last Month Day Year APRIL 26 1956
5. SEX FEMALE		6. COLOR OR RACE WHITE	7. MARRIED NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH FEB 26, 1910		9. AGE (In years last birthday) 46 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STITCHER		10b. KIND OF BUSINESS OR INDUSTRY SHOE FACTORY	
11. BIRTHPLACE (State or foreign country) CARROLL CO., MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME HOWARD A. BIXLER		14. MOTHER'S MAIDEN NAME ANNA R. MYERS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 228-29-3172 17. INFORMANT MR. STERLING A. MILLER, WESTMINSTER, MD.	
Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO 420.1			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH Minutes	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .		DATE SIGNED 4/26/56	
ACTUAL SIGNATURE <i>James T. Marsh</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) JAMES T MARSH		22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	
22b. DATE THEREOF APRIL 29'56		22c. NAME OF CEMETERY OR CREMATORIAL MEADOW BRANCH CEM.	
22d. LOCATION (City, town, or county) RURAL, WESTMINSTER MD		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. E. Meyers Jr. Westminster Md.</i>		ADDRESS 4-22-56	24a. REC'D BY REGISTRAR Harold Miller
		24b. REGISTRAR'S SIGNATURE	

RECEIVED APRIL 30 1956
BUREAU K-5
APR 30 1956
RECORDED & INDEXED
SEARCHED
SERIALIZED
FILED
FBI - WILMINGTON
HOME OF A. DIXIE LEE
ANNIE K. WELLS
SCHOOL DIRECTOR
CLICHET
FEDERAL BUREAU OF INVESTIGATION
WILMINGTON FIELD OFFICE
U.S. DEPARTMENT OF JUSTICE
WILMINGTON, DELAWARE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3898

CERTIFICATE OF DEATH

03876

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death by the attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Carroll</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MD.</i>		b. COUNTY <i>CARROLL</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>RURAL, WESTMINSTER RD#7</i>		c. LENGTH OF STAY IN 1b <i>25 YRS.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>RURAL, WESTMINSTER RD#7</i>		d. STREET ADDRESS <i>PLEASANT VALLEY</i>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>PEASANT VALLEY</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)		First <i>J.</i>	Middle <i>MILTON</i>	Last <i>MILLER</i>	4. DATE OF DEATH <i>APRIL 14 1956</i>	Month <i>APRIL</i>	Day <i>14</i>	Year <i>1956</i>
5. SEX <i>MALE</i>	6. COLOR OR RACE <i>WHITE</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <i>JAN. 1, 1902</i>	9. AGE (In years last birthday) <i>54 yrs.</i>	IF UNDER 1 YEAR Months <i>5</i>	IF UNDER 24 HRS. Days <i>4</i>	Hours <i>0</i>	Min. <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>MACHINE OPERATOR</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>CAMBRIDGE RUBBER CO.</i>		11. BIRTHPLACE (State or foreign country) <i>MILLERS, CARROLL CO., MD. U.S.A.</i>		12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME <i>JOHN MILLER</i>		14. MOTHER'S MAIDEN NAME <i>CLARA HOFFACKER</i>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i>		16. SOCIAL SECURITY NO. <i>216-03-9170</i>		17. INFORMANT <i>MRS. J. HELWIG MILLER, WESTMINSTER RD#7</i>		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i>		DUE TO <i>Coronary occlusion</i>		INTERVAL BETWEEN ONSET AND DEATH <i>Sudden</i>				
Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last.		(b) DUE TO <i>Ch. Myocarditis</i>	(c)			<i>Several years</i>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. p. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <i>Feb. 1, 1956</i> , to <i>apr 14, 1956</i> , that I last saw the deceased alive on <i>apr 12, 1956</i> , and that death occurred at <i>2 P.M.</i> from the causes and on the date stated above.								ADDRESS (Street, city or town, state) <i>Hanover, Pa.</i>
ACTUAL SIGNATURE <i>Mark Redding</i>		DATE SIGNED <i>4/15/56</i>						
PHYSICIAN'S NAME (Type) <i>MARK REDDING, M.D.</i>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		22b. DATE THEREOF <i>APRIL 17, 1956</i>		22c. NAME OF CEMETERY OR CREMATORY <i>PLEASANT VALLEY CEM. WESTMINSTER RD#7 Md.</i>		22d. LOCATION (City, town, or county) (State)		
23. FUNERAL DIRECTOR'S SIGNATURE <i>J.E. Myers, Jr. Westminster, Md.</i>		ADDRESS		24a. REC'D BY REGISTRAR DATE <i>4-14-56</i>		24b. REGISTRAR'S SIGNATURE <i>Hamlet Miller</i>		

87 20000728-002438 40 THEATRE OF 37AY2 044398

REAU Y. S.

APR 17 1956

RECEIVED

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after the deceased has been removed from your hospital or office. If you do not receive this certificate within 24 hours, please advise the attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it may be retained by the funeral director. This certificate should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Page 4

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03877

3899

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH a. COUNTY Carroll		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Finksburg		c. LENGTH OF STAY IN lb life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R 1 Sandymount		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Finksburg	
3. NAME OF DECEASED (Type or print) Bonnie Carol Monath		d. STREET ADDRESS R 1 Sandymount	
4. DATE OF DEATH April 21 1956		Month	Day Year
S. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 26, 1955
9. AGE (In years lost birthday) yrs. 4		IF UNDER 1 YEAR Months 4	IF UNDER 24 HRS. Days 25
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) - - - - -		10b. KIND OF BUSINESS OR INDUSTRY - - - - -	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Howard J. Monath		14. MOTHER'S MAIDEN NAME Alma C. Tipton	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. - - - - -	
17. INFORMANT Address Howard J. Monath R 1 Finksburg, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia DUE TO 493X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH. 4-17-56			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4-18- 1956 , to 4-21- 1956 , that I last saw the deceased alive on 4-20 1956 , and that death occurred at 3 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Westminster Md 4-21-56			
ACTUAL SIGNATURE W. C. Jennette		DATE SIGNED 4-21-56	
PHYSICIAN'S NAME (Type) W. C. Jennette		M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Apr. 22, 1956	
22c. NAME OF CEMETERY OR CREMATORIUM Sandymount		22d. LOCATION (City, town, or county) (State) Sandymount, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John R. Byers Westminster, Md.		24a. REC'D BY REGISTRAR DATE 4-23-56	
		24b. REGISTRAR'S SIGNATURE Harold Miller	

81 ESTATE PLANNING—ESTATE PLANNING—ESTATE PLANNING

BUREAU U. S.

APR 25 1956

KECEVAD

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3900

03878

71

CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after the deceased has been signed by the attending physician and completely filled in by the funeral director. This certificate may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: Under this certificate as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Page 4

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE	
CARROLL MARYLAND		MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN lb	b. COUNTY	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
UNIONTOWN RURAL	3 WEEKS	CARROLL	RURAL
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	d. STREET ADDRESS		
3. NAME OF DECEASED (Type or print)		First	Middle
FRANKLIN EUGENE MORT JR			
4. DATE OF DEATH	Month	Day	Year
APRIL	9	9	1956
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH
M	W	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	MARCH 19-1956
9. AGE (In years lost birthday) yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. Hours
3 WEEKS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
NONE	NONE	MARYLAND	USA
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME		
FRANKLIN E MORT	MABEL MYERS		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> NO	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
	NONE	FRANKLIN E MORT	UNIONTOWN MD
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 751X		2 days.	
DUE TO Meingitis			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Spina bifida - Meingitis		21 days	
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from April 7, 1956, to April 9, 1956, that I last saw the deceased alive on April 9, 1956, and that death occurred at 1:30 P.M., from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED James J. Marsh M.D. Westminster Md 4/19/56	
ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) JAMES J. MARSH			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF APRIL 11-1956	22c. NAME OF CEMETERY OR CREMATORIAL LUTHERAN	22d. LOCATION (City, town, or county) UNIONTOWN MD
23. FUNERAL DIRECTOR'S SIGNATURE DD Hartler & Sons New Windsor Md		24a. REC'D BY REGISTRAR DATE 4/11/56	24b. REGISTRAR'S SIGNATURE Margaret R. Englar

CERTIFICATE OF DEATH

BUREAU V. S.

APR 24 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 2,3, Film G195 1-9-56 et

03878 #78
Reg. Dist. No.

3971

CERTIFICATE OF DEATH

1. PLACE OF DEATH o. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE	
CARROLL MARYLAND		MD	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b RURAL Life	
TAYLORSVILLE		Near- Taylorsville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS RFD # 5, Westminster	
3. NAME OF DECEASED (Type or print)		First JESSE	Middle KESTER
3. NAME OF DECEASED (Type or print)		Myers	4. DATE OF DEATH Month 4
5. SEX M		6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH 23 Oct		9. AGE (In years last birthday) 66 yrs.	10. IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) CARROLL MD
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Cleveland	
14. MOTHER'S MAIDEN NAME ANNIE STEM		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. 220 34 5852		17. INFORMANT ANGIE MEYERS	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest		INTERVAL BETWEEN ONSET AND DEATH 1/10	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 420.0		7st 56	
(b) DUE TO Coronary Thrombosis		TO April 56	
(c) DUE TO Arteriosclerotic heart disease			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Nat while at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 23 March, 1956 , to 2 April, 1956 , that I last saw the deceased alive on 2 April 56 , 19 56 , and that death occurred at 3:45 AM , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) SYKESVILLE, MD	
ACTUAL SIGNATURE Howard E. Hall MD		DATE SIGNED 2 April 56	
PHYSICIAN'S NAME (Type) HOWARD E. HALL		22. NAME OF CEMETERY OR CREMATORIAL Pipe Creek	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF Apr 4-56	
22c. LOCATION (City, town, or county) Near UNIONTOWN MD		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE RAYMOND K. WRIGHT UNION Bridge		24a. REC'D BY REGISTRAR 4/4/56	
ADDRESS May Fairview		24b. REGISTRAR'S SIGNATURE Relia P. Robb	

CERTIFICATE OF DEATH

BUREAU V. A.

APR 5 1960

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03880

CERTIFICATE OF DEATH

Reg. Dist. No.

76

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL WESTMINSTER</u>		b. COUNTY <u>CARROLL</u>	
c. LENGTH OF STAY IN lb <u>38 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL WESTMINSTER</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PEASANT VALLEY</u>		d. STREET ADDRESS <u>PEASANT VALLEY</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <u>LEROY</u>	Middle <u>EDWARD</u>	Last <u>MYERS</u>
4. DATE OF DEATH	Month <u>APRIL</u>	Day <u>3</u>	Year <u>1956</u>
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <u>FEB. 5, 1918</u>
9. AGE (In years lost birthday) <u>38 yrs.</u>	10. IF UNDER 1 YEAR Months <input type="checkbox"/>	11. IF UNDER 24 HRS. Days <input type="checkbox"/>	12. IF UNDER 24 HRS. Hours <input type="checkbox"/> Min. <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MECHANIC</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>T.V. and Optometrist Pleasant Valley, Carroll, Md.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>Laura Herman</u>	
13. FATHER'S NAME <u>D. Leroy Myers</u>		14. MOTHER'S MAIDEN NAME <u>Laura Herman</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>216-05-1402</u>	
17. INFORMANT <u>MRS. LEROY E. MYERS, WESTMINSTER, MD.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Arteries</u> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO <u>Hypertension</u> (c)		INTERVAL BETWEEN ONSET AND DEATH	
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <u>Rural Westminster</u> (County) <u>Carroll</u> (State) <u>Md.</u>	
21. I certify that I attended the deceased from <u>May 1, 1956</u> to <u>Apr 5, 1956</u> that I last saw the deceased alive on <u>Apr 2, 1956</u> , and that death occurred at <u>6 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W.C. JENNETTE</u>		ADDRESS (Street, city, town, state) <u>Westminster, Md.</u>	
PHYSICIAN'S NAME (Type) <u>W.C. JENNETTE</u>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>APRIL 6, 56</u>	
22c. NAME OF CEMETERY OR CREMATORIAL <u>PLEASANT VALLEY CEM. RURAL WESTMINSTER, MD.</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J.S. Myers Jr. - Westminster, Md.</u>		24a. REC'D BY REGISTRAR <u>Harriet Miller</u>	
ADDRESS <u>J.S. Myers Jr. - Westminster, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Harriet Miller</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the physician or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED STATE OF NEW YORK - GOVERNOR

CERTIFICATE OF DEATH

BUREAU V. S.

APR 9 1968

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3903

CERTIFICATE OF DEATH

0388174
Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the death. It may be retained by the physician or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Page 4

1. PLACE OF DEATH a. COUNTY Carroll		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Sykesville		c. LENGTH OF STAY IN 1b 2 M 7 D		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		d. STREET ADDRESS 19 M, 27th Street			
d. NAME OF HOSPITAL (If not in hospital, give street address) Springfield State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) George		First	Middle	Last	4. DATE OF DEATH NIELSON	Month	Day	Year	
5. SEX Male	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 8/14/87	9. AGE (In years last birthday) 68 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY steel		11. BIRTHPLACE (State or foreign country) unknown		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME unknown			14. MOTHER'S MAIDEN NAME unknown						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unk.		16. SOCIAL SECURITY NO. 213-09-2423		17. INFORMANT Record, Springfield State Hospital		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the lung DUE TO 163X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Bronchopneumonia with multiple lung abscesses DUE TO (c) Arteriosclerosis DUE TO 2-3 months years									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Chr. Brain Syndrome assoc. with cerebral arteriosclerosis, with psychosis									
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)									
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)									
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED White at work <input type="checkbox"/> Nat white at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)	(State)
21. I certify that I attended the deceased from 2/10 , 19 56 , to 4/16 , 19 56 , that I last saw the deceased alive on 4/15 , 19 56 , and that death occurred at 7:00A M, from the causes and on the date stated above.									
ADDRESS (Street, city or town, state)									
DATE SIGNED									
Agustin del Campo, M.D., Sykesville, Maryland									
ACTUAL SIGNATURE		PHYSICIAN'S NAME (Type)		1/16/56					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/19/56		22c. NAME OF CEMETERY OR CREMATORIUM Oak Lawn Cemetery		22d. LOCATION (City, town, or county) Baltimore, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Schimunek Funeral Home, Inc.		ADDRESS 2601 E. Madison St.		24a. REC'D BY REGISTRAR APR 19 1956		24b. REGISTRAR'S SIGNATURE Darryl Keay			

CERTIFICATE OF DEATH

REGISTRATION

SEARCHED
INDEXED
FILED

NAME OF DECEASED		AGE		SEX	
JAMES L. HARRIS		65		M	
ADDRESS		CITY		STATE	
1000 N. 10th Street, Milwaukee, Wisconsin		Milwaukee		Wisconsin	
NAME AND ADDRESS OF PHYSICIAN		NAME AND ADDRESS OF FUNERAL DIRECTOR		NAME AND ADDRESS OF CEMETERY	
Dr. J. W. Johnson, 1000 N. 10th Street, Milwaukee, Wisconsin		F. J. S. Mortuary, 1000 N. 10th Street, Milwaukee, Wisconsin		Milwaukee Cemetery, Milwaukee, Wisconsin	
DEATH CERTIFIED AS OCCURRING IN THE CITY OF MILWAUKEE, WISCONSIN					
APPROVED AND SIGNED BY THE CLERK OF THE DEPARTMENT OF HEALTH					
APRIL 19, 1956					

BUREAU V. 2
APR 19 1956
RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03883
774

3905

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll		MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Garrett Alleg.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 4 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LaVale (Cumberland)		d. STREET ADDRESS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital					e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Simon	Middle J.	Last Orendorf	4. DATE OF DEATH April 20	Month Day Year 1956	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH 5/21/78	9. AGE (In years last birthday) 77 yrs.	IF UNDER 1 YEAR Months - Days - Hours - Min. -	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Agriculture		11. BIRTHPLACE (State or foreign country) Maryland		
12. CITIZEN OF WHAT COUNTRY? U.S.A.						
13. FATHER'S NAME Joel Orendorf		14. MOTHER'S MAIDEN NAME Sarah Bittinger				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 24-56078		17. INFORMANT Springfield Hospital records, Sykesville, Md.	Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH				
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Infarction of myocardium anterior & lateral wall		minutes				
420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause first. (b) Coronary thrombosis		days				
DUE TO (c)						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour a. m. 19 p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) 4/20/56	(County) 4/20/56	(State)
21. I certify that I attended the deceased from 4/17/56 , 19, to 4/20/56 , 19, that I last saw the deceased alive on 4/20/56 , 19, and that death occurred at 10:20 AM , from the causes and on the date stated above.		ADDRESS (Street, city or town, state)				
ACTUAL SIGNATURE <i>Edmund Lusthaus</i>		DATE SIGNED 4/20/56				
PHYSICIAN'S NAME (Type) Edmund Lusthaus, M.D.						
22a. BURIAL, CREMATION, REMOVAL (Specify) Folk	22b. DATE THEREOF 4/23/56	22c. NAME OF CEMETERY OR CREMATORIAL FOLK	22d. LOCATION (City, town, or county) RURAL GRANTSVILLE GARRET CO MD			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Donald J. Newman</i>	ADDRESS GRANTSVILLE, MD	24a. REC'D BY REGISTRAR DATE 4-21-56				
				24b. REGISTRAR'S SIGNATURE <i>C. Harry Zeller</i>		

BUREAU U. S.

APR 24 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after
 may be retained by hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18						03882 74	
3904			CERTIFICATE OF DEATH				Reg. Dist. No.
1. PLACE OF DEATH a. COUNTY Carroll			MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY		
c. LENGTH OF STAY IN lb lyr. 9 days			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			d. STREET ADDRESS <i>Unk -</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First JOSEPH	Middle ALFRED	Last PARE	4. DATE OF DEATH April 7 1956		
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 10-1-87	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stock Clerk		10b. KIND OF BUSINESS OR INDUSTRY <i>Unk -</i>		11. BIRTHPLACE (State or foreign country) Vermont		9. AGE (In years lost birthday) 68 yrs. IF UNDER 1 YEAR <input type="checkbox"/> Months 0 Dofs 0 Hours 0 Min. 0 IF UNDER 24 HRS. <input type="checkbox"/>	
13. FATHER'S NAME Joseph L. Pare			14. MOTHER'S MAIDEN NAME Amanda Pare				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? <input checked="" type="checkbox"/> (If yes, give war or dates of service) Yes 1906 to 1910			16. SOCIAL SECURITY NO. <i>Unk -</i>		17. INFORMANT Springfield State Hospital - Sykesville, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the lung w. metastasis DUE TO 163X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Chronic brain syndrome assoc. with intoxication, alcohol intoxication, without qualifying phrase, plus cerebral arteriosclerosis.							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Unk -</i>					
20c. TIME OF INJURY Month, Day, Year Hour o. p. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Unk -</i>		20f. (City or town) (County) Unk - (State) Unk -	
21. I certify that I attended the deceased from 3-28 1955 , to 4-7 1956 , that I last saw the deceased alive on 4-7 1956 , and that death occurred at 10:15A M , from the causes and on the date stated above. ACTUAL SIGNATURE <i>Walther H. Sonnenfeldt</i> M.D. ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 4-7-56 PHYSICIAN'S NAME (Type) Walther H. Sonnenfeldt Sykesville, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-12-56		22c. NAME OF CEMETERY OR CREMATORIUM <i>Springfield</i>		22d. LOCATION (City, town, or county) <i>Unk -</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John H. Wright</i>		ADDRESS <i>Unk -</i>		24a. REC'D BY REGISTRAR DATE 4-12-56		24b. REGISTRAR'S SIGNATURE <i>C. Harry Weir</i>	

PR 17 1956

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INSTRUCTIONS

1

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-5 10W

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

3936 CERTIFICATE OF DEATH

03884

Reg. Dist. No. 74

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Rural--Sykesville	Carroll MARYLAND LENGTH OF STAY (in this place) 11 yrs.	STATE Maryland CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural--Sykesville STREET ADDRESS Eldersburg	COUNTY Carroll If rural give location Eldersburg
3. NAME OF DECEASED (First) SHRIVER (Middle) E. (Last) PICKETT (Type or Print)		4. DATE OF DEATH (Month) April (Day) 7, (Year) 1956	
5. SEX male	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, married	8. DATE OF BIRTH 10-8-1887
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farmer retired		10b. KIND OF BUSINESS OR INDUSTRY owner	11. BIRTHPLACE (State or foreign country) Maryland
13. FATHER'S NAME John W. Pickett		14. MOTHER'S MAIDEN NAME Eliza Jane Penn	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) no		16. SOCIAL SECURITY NO. none	17. INFORMANT & ADDRESS Mrs. Fannie E. Pickett, Same
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <i>420.0</i> IMMEDIATE CAUSE (A) <i>Cardiac Arrest</i>		INTERVAL BETWEEN ONSET AND DEATH <i>Several years</i>	
ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, (B) GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO <i>Arterosclerotic heart disease</i>			
(C) <i>Hypertension - C.V.A.</i>		7 April 56	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <input type="checkbox"/> (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
M. at work		21e. INJURY OCCURRED While Not while at work	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>7 April</i> , 1956, to <i>7 April</i> , 1956, that I last saw the deceased alive on <i>7 April</i> , 1956, and that death occurred at <i>11:01 A.M.</i> from the causes and on the date stated above.			
SIGNATURE <i>Howard E Hall</i>		ADDRESS (Street, city, town, state) <i>Sykesville, Md</i> DATE SIGNED <i>8 April 56</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	DATE THEREOF 4-10-1956	NAME OF CEMETERY OR CHAMBERS Ebenezer	LOCATION (City, town, or county) Carroll Co., Maryland (State)
24. REC'D BY REGISTRAR	REGISTRAR'S SIGNATURE <i>C. Harry Weber</i>	25. FUNERAL DIRECTOR'S SIGNATURE C.M.Waltz, Winfield, Md.	
DATE <i>4-10-56</i>	ADDRESS		

WISCONSIN STATE CHARTER

REGISTRATION OF DOCUMENT

REGISTRATION NUMBER

BUREAU V. S.

APR 13 1956

REGISTRATION

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3907

CERTIFICATE OF DEATH

03885
74

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Carroll		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Sykesville		c. LENGTH OF STAY IN 1b 1 M, 18 D		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		d. STREET ADDRESS 2810 Rosalie Avenue	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) John		First H.	Middle RENNER	4. DATE OF DEATH 14	Month 12	Day 19	Year 56
5. SEX Male	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 1/5/80	9. AGE (In years last birthday) 76 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Druggist		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Renner				14. MOTHER'S MAIDEN NAME Mollie HELDOEFER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. none		17. INFORMANT Record, Springfield State Hospital, Sykesville		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary thrombosis DUE TO (c) Arteriosclerotic cardiovascular disease INTERVAL BETWEEN ONSET AND DEATH days days years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Chronic brain syndrome associated with cerebral arteriosclerosis							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ADDRESS (Street, city or town, state)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Sykesville, Maryland		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2/26 , 19 56 , to 4/12 , 19 56 , that I last saw the deceased alive on 4/12 , 19 56 , and that death occurred at 9 PM M, from the causes and on the date stated above. ACTUAL SIGNATURE <i>Agustín del Campo</i> M.D. ADDRESS (Street, city or town, state) Sykesville, Maryland DATE SIGNED 4/12/56							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Apr. 16. 1956		22c. NAME OF CEMETERY OR CREMATORIUM Baltimore Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore Md.	
23. FUNERAL DIRECTOR'S SIGNATURE HENRY SANDER & SONS, INC. Baltimore Md.		ADDRESS <i>George F. Sanders</i>		24a. REC'D BY REGISTRAR DATE 7/1956		24b. REGISTRAR'S SIGNATURE <i>Henry Sander</i>	

81. BROWNTAIL—INDIAN 30 THE 10TH AFRICAN STATE CHAMPION

APR 17 1956

РЕГЕИВ ЕД

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTORS: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3908

CERTIFICATE OF DEATH

03886

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Sykesville		c. LENGTH OF STAY IN 1b 2Y 1M 9D		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		3 Y O 1 - 4			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		d. STREET ADDRESS 517 S. Register Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) BALBINA, Barbara		First	Middle	Last	4. DATE OF DEATH 4 25 1956	Month	Day	Year	
5. SEX Female	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH 10/22/00	9. AGE (In years last birthday) 55 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer Langrai		10b. KIND OF BUSINESS OR INDUSTRY packing houses		11. BIRTHPLACE (State or foreign country) Polish Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Edward Skrucha			14. MOTHER'S MAIDEN NAME Mary Anna Pipczynski						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 212-07-9013		17. INFORMANT Record, Springfield State Hospital		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease						INTERVAL BETWEEN ONSET AND DEATH years			
DUE TO 420.0									
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Involutional psychotic reaction						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) Sykesville (State) Maryland			
21. I certify that I attended the deceased from 3/17 , 19 56 , to 4/25 , 19 56 , that I last saw the deceased alive on 4/25 , 19 56 , and that death occurred at 1:22 PM , from the causes and on the date stated above.						ADDRESS (Street, city or town, state) Sykesville, Maryland DATE SIGNED 4/25/56			
ACTUAL SIGNATURE Walther H. Sonnenfeldt		M.D.							
PHYSICIAN'S NAME (Type) Walther H. Sonnenfeldt, M. D.									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/28/56		22c. NAME OF CEMETERY OR CREMATORIUM St. Stanislaus Cem.		22d. LOCATION (City, town, or county) Baltimore City			
23. FUNERAL DIRECTOR'S SIGNATURE John M. Weber		ADDRESS 401 S. Chester Street		24a. REG'D. BY REGISTRAR APR 27 1956		24b. REGISTRAR'S SIGNATURE C. Harry Steers			

APR 27 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death by the physician or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Carroll		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural Westminster		c. LENGTH OF STAY IN 1b life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R 6 Smallwood		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Howard		First Franklin	Middle Spencer
4. DATE OF DEATH April 28, 1956		Sr. Spencer	Month Day Year April 28 1956
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 8, 1882
9. AGE (In years lost birthday) 74 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired Farmer	11. KIND OF BUSINESS OR INDUSTRY Own Farm	12. BIRTHPLACE (State or foreign country) Carroll County, Md.
13. FATHER'S NAME William Ernest Spencer	14. MOTHER'S MAIDEN NAME Amanda Lockard		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO. - - - - -	17. INFORMANT Ralph H. Spencer R 6 Westminster, Md.	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) asphyxiation - caused by fire			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) in trailer while deceased 15 minutes			
DUE TO (c) was asleep -			
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home
20f. (City or town) Carroll		(County) Carroll	(State)
21. I certify that I attended the deceased from 4/28 , 19 56 , to 4/28 , 19 56 , that I last saw the deceased alive on 4/28 , 19 56 , and that death occurred at 10 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>S. Luther Bare</i>		ADDRESS (Street, city or town, state) Mt. Pleasant Cem.	DATE SIGNED 5-1-56
PHYSICIAN'S NAME (Type) S. Luther Bare		Westminster Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF May 1, 1956	22c. NAME OF CEMETERY OR CREMATORIAL Mt. Pleasant Cem.	22d. LOCATION (City, town, or county) (State) Gamber, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE John R. Byers		ADDRESS Westminster, Maryland	24a. REC'D BY REGISTRAR Hannan
		DATE 5-1-56	24b. REGISTRAR'S SIGNATURE Hannan

THE STATE GOVERNMENT OF MARYLAND - BALTIMORE 18

CERTIFICATE OF DEATH

BUREAU V. S.

MAY 3 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3910

CERTIFICATE OF DEATH

03888
74

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after the funeral director, may be retained by the hospital or attending physician and completely filled in by the funeral director.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Page 4

1. PLACE OF DEATH a. COUNTY Carroll		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Sykesville		c. LENGTH OF STAY IN lb 4 mos. 9 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		d. STREET ADDRESS 803 Easley Street	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				d. STREET ADDRESS 803 Easley Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First WILLIAM	Middle WILSON	Last STABLER	4. DATE OF DEATH 4	Month 4	Day 3	Year 19 56
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH 12/11/00	9. AGE (In years last birthday) 55	IF UNDER 1 YEAR Months 55	IF UNDER 24 HRS. Hours 55	IF UNDER 24 HRS. Min. 55
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Budget official		10b. KIND OF BUSINESS OR INDUSTRY Government		11. BIRTHPLACE (State or foreign country) Montgomery County, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Tarlton B. Stabler		14. MOTHER'S MAIDEN NAME Rebecca Moore					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unknown		16. SOCIAL SECURITY NO. YES		17. INFORMANT Record, Springfield State Hospital, Sykesville		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Thrombosis of coronary arteries with acute in- DUE TO farction of the left ventricle wall						INTERVAL BETWEEN ONSET AND DEATH Days	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Arteriosclerosis		DUE TO				years	
		(b) Arteriosclerosis					
		(c) Degenerating pulmonary infarction				Weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Chronic brain syndrome associated with circulatory disturbance other than cerebral arteriosclerosis, with psychotic reaction						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED: (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3/20 , 19 56 , to 4/3 , 19 56 , that I last saw the deceased alive on 4/3 , 19 56 , and that death occurred at 12:45 PM from the causes and on the date stated above. ADDRESS (Street, city or town, state) Walther H. Sonnenfeldt, M.D.						DATE SIGNED 4/3/56	
ACTUAL SIGNATURE Walther H. Sonnenfeldt, M.D.							
PHYSICIAN'S NAME (Type) Walther H. Sonnenfeldt, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 4/5/56	22c. NAME OF CEMETERY OR CREMATORIUM FRIENDS CEMETERY		22d. LOCATION (City, town, or county) MONTGOMERY COUNTY, MARYLAND		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Warner S. Humphrey,		ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR DATE 4-5-56		24b. REGISTRAR'S SIGNATURE C. Henry Lee	

BUREAU V. S.

9961 6 25W

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03890

3911

CERTIFICATE OF DEATH

Reg. Dist. No. 76

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Carroll</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Carroll</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural Westminster</i>		c. LENGTH OF STAY IN lb <i>50 yrs</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural Westminster</i>		d. STREET ADDRESS <i>Washington Road</i>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington Road</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) <i>JESSE EMANUEL</i>		First	Middle	Lost	4. DATE OF DEATH <i>APRIL 30 1956</i>	Month	Day	Year
5. SEX <i>Male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Feb 3, 1869</i>		9. AGE (In years lost birthday) <i>87 yrs.</i>	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>miner/miner</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>power</i>		11. BIRTHPLACE (State or foreign country) <i>Carroll Co. Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
13. FATHER'S NAME <i>Emmanuel Stoner</i>		14. MOTHER'S MAIDEN NAME <i>Maria Royer</i>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>—</i>		17. INFORMANT <i>Mrs. Jesse E. Stoner, Westminster, Md</i>		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>442X</i>		DUE TO <i>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first.</i>		INTERVAL BETWEEN ONSET AND DEATH <i>Palpumonia (Probable Virus) April 16/56</i>				
		(b) DUE TO <i>Gastroenteritis</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
		(c) DUE TO <i>Renal disease (Senility)</i>						
20a. MEDICAL CERTIFICATION		20b. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour o. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <i>Westminster</i>		(County) <i>Carroll</i> (State) <i>Md</i>
21. I certify that I attended the deceased from <i>April 16, 1956</i> , to <i>April 30, 1956</i> , that I last saw the deceased alive on <i>April 15, 1956</i> , and that death occurred at <i>5:15 PM</i> , from the causes and on the date stated above.						ADDRESS (Street, city or town, state) <i>109 Lemoine Street, Westminster, Md</i>		DATE SIGNED <i>4/30/56</i>
ACTUAL SIGNATURE <i>Regina Speicher</i>								
PHYSICIAN'S NAME (Type) <i>Regina Speicher</i>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>May 3/56</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Westminster Cemetery, Westminster, Md.</i>		22d. LOCATION (City, town, or county) <i>Westminster, Md.</i>		(State) <i>Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. S. Myers Jr.</i>		ADDRESS <i>Westminster, Md.</i>		24a. REC'D BY REGISTRAR <i>5-1-56</i>		24b. REGISTRAR'S SIGNATURE <i>Hornio Miller</i>		

CERTIFICATE OF DEATH

BUREAU V. S.

MAY 3 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03891

3861

CERTIFICATE OF DEATH

Reg. Dist. No. 76

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death by the attending physician and completely filled in by the funeral director.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Page 4
VS A15 (4)
15M 9/55

1. PLACE OF DEATH a. COUNTY CARROLL		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE M.D.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WESTMINSTER		c. LENGTH OF STAY IN 1b 20 yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 27 COLONIAL AVE.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First THELMA	Middle BLANCHE	Last STONER
4. DATE OF DEATH 4-28	Month 1956	Day 1956	Year
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JAN. 14-1908
9. AGE (In years last birthday) yrs. 48	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE	11. BIRTHPLACE (State or foreign country) M.D.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME CHARLES HUGHES	14. MOTHER'S MAIDEN NAME MOLLIE J. SHETTLE		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO	16. SOCIAL SECURITY NO. NONE	17. INFORMANT J. ALBERT STONER	Address 77 COLONIAL AVE. WESTMINSTER, MD.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 174X DUE TO Coronary Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 2 Ulcers 2 Liver 3 Lung			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH (1) 4 yrs (2) 2 yrs (3) 2 months
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. p.m. p. m.	Month, Day 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 2-16- , 1956, to 4-28- , 1956, that I last saw the deceased alive on 4-27-1956 , and that death occurred at 11 a.m. from the causes and on the date stated above.			
ACTUAL SIGNATURE W.C. Jeannette	ADDRESS (Street, city or town, State) 103 W Main Westminster Md 21097		
PHYSICIAN'S NAME (Type) Wm Carl Jeannette, MD	DATE SIGNED 5-1-56		
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF MAY 2, 1956	22c. NAME OF CEMETERY OR CREMATORIUM XANDY MOUNT GEM.	22d. LOCATION (City, town, or county) CARROLL CO. MD.
23. FUNERAL DIRECTOR'S SIGNATURE H BANISTER & SON WESTMINSTER MD.	ADDRESS HBANISTER & SON WESTMINSTER MD.	24a. REC'D BY REGISTRAR DATE 5-2-56	24b. REGISTRAR'S SIGNATURE Harriet Miller

8801 - CERTIFICATE OF DEATH

A A 2

BUREAU V. S.
RECEIVED
MAY 4 1956

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03892

3912

CERTIFICATE OF DEATH

Reg. Dist. No. 33

1. PLACE OF DEATH o. COUNTY <i>Carroll</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Sykesville</i>		c. LENGTH OF STAY IN lb <i>4 weeks</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Springfield State Hospital</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hampstead</i>	
3. NAME OF DECEASED (Type or print) <i>William Grant Sterrig.</i>		d. STREET ADDRESS <i>R.D. #2.</i>	
First <i>William</i>		Middle <i>Grant</i>	Last <i>Sterrig.</i>
4. DATE OF DEATH <i>4</i>		Month <i>4</i>	Day <i>4</i>
		Year <i>1956</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <i>8-3-1865</i>
		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. AGE (In years from birth) yrs. <i>90</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>farmer</i>		10b. KIND OF BUSINESS OR INDUSTRY	
		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>Ephraim Sterrig</i>		14. MOTHER'S MAIDEN NAME <i>Irene Fowle</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO.	
		17. INFORMANT <i>Hospital records</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Bronchopneumonia</i>		<i>7 days</i>	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. <i>#20.0</i>			
(b) <i>Arteriosclerotic heart disease</i>		<i>2 months</i>	
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>O.B.S due to Disturbance of Metabolism without giving signs</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i>		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <i>Baltimore</i> (County) <i>Baltimore</i> (State) <i>Md.</i>	
21. I certify that I attended the deceased from <i>3-8-</i> , 19 <i>56</i> , to <i>4-4-</i> , 19 <i>56</i> , that I last saw the deceased alive on <i>4-4-</i> , 19 <i>56</i> , and that death occurred at <i>11:35 P.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Walter H. Sonnenfeld</i>		ADDRESS (Street, city or town, state) <i>Springfield State Hospital</i> DATE SIGNED <i>4/4/56</i>	
PHYSICIAN'S NAME (Type) <i>Walter H. Sonnenfeld</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>4-7-56</i>	
22c. NAME OF CEMETERY OR CREMATORIAL <i>Graves Run</i>		22d. LOCATION (City, town, or county) <i>Baltimore</i> (State) <i>Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Edgar C. Tipton</i>		ADDRESS <i>Hampstead</i>	
24a. REC'D BY REGISTRAR DATE <i>4-5-56</i>		24b. REGISTRAR'S SIGNATURE <i>Harry B. Elsner</i> <i>C. Harry Steers</i>	

Page 4
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death by the physician or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 22 hours after death.

22

THE UNITED STATES GOVERNMENT - REFERENCE LIBRARY

CERTIFICATE OF DEATH

BUREAU V. S.

APR 9 19

REGISTRY

EDWARD JAMES LEON (S) 44-3-12-1
DEATH CERTIFICATE
12-2-4 11/11/1948 C. L. G. E. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3913

CERTIFICATE OF DEATH

03893

Reg. Dist. No.

81

1. PLACE OF DEATH a. COUNTY CARROLL		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND		b. COUNTY CARROLL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) UNION BRIDGE		c. LENGTH OF STAY IN 1b YEARS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) UNION BRIDGE		d. STREET ADDRESS RURAL	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION RURAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) MARY		First	Middle	Last	4. DATE OF DEATH Month Day Year APRIL 25 1956	Month	Day Year
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 2/24/1874	9. AGE (In years last birthday) 82 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEKEEPER		10b. KIND OF BUSINESS OR INDUSTRY AT HOME		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME J. THADDEUS STARR		14. MOTHER'S MAIDEN NAME REBECCA CROUSE		Address MD. J.H. STUFFLE, UNION BRIDGE, RURAL			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 189-09-1981		17. INFORMANT J.H. STUFFLE		INTERVAL BETWEEN ONSET AND DEATH 10 days	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED White Not white of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) HANOVER		20f. (City or town) (County) (State) HANOVER PENNA.	
21. I certify that I attended the deceased from Apr 24 1956 to Apr 25 1956 (that) last saw the deceased alive on Apr 24 1956 and that death occurred at HANOVER , M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) HANOVER PENNA. DATE SIGNED 4/27/56							
ACTUAL SIGNATURE J.H. MESSLER M.D.		PHYSICIAN'S NAME (Type) J.H. MESSLER M.D.					
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 4/28/56		22c. NAME OF CEMETERY OR CREMATORIAL MT. OLIVET CEM.		22d. LOCATION (City, town, or county) (State) HANOVER PENNA.	
23. FUNERAL DIRECTOR'S SIGNATURE D.O. Hartley & Sons, Union Bridge		ADDRESS REC'D BY REGISTRAR DATE 4/27/56 REGISTRAR'S SIGNATURE Edie L. Repp					

CERTIFICATE OF DEATH

3309

RECEIVED
APR 30 1956
BUREAU X-5

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS Aisc 1-5 10W

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

3914

CERTIFICATE OF DEATH

03894

Reg. Dist. No. 74

1. PLACE OF DEATH			2. USUAL RESIDENCE (HOME) OF DECEASED		
COUNTY CITY TOWN	Carroll (If outside corporate limits, write RURAL and give nearest town) Rural - Sykesville	MARYLAND LENGTH OF STAY (in this place) since 4/5/47	STATE CITY TOWN	Maryland (If outside corporate limits, write RURAL and give nearest town) Westminster	COUNTY STREET ADDRESS
HOSPITAL OR INSTITUTION OR STREET ADDRESS	Springfield State Hospital		21 Park Avenue (If rural give location)		
3. NAME OF DECEASED (Type or Print)	(First) Cornelius	(Middle) Sleight	(Last) TARKINGTON	4. DATE OF DEATH April 19 1956	
5. SEX male	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) married	8. DATE OF BIRTH March 25, 1883	9. AGE last birthday 73	IF UNDER 1 YEAR Months - Days - Hours - Min. - yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter			10b. KIND OF BUSINESS OR INDUSTRY Carpentry	11. BIRTHPLACE (State or foreign country) Washington Co., North Carolina	12. CITIZEN OF WHAT COUNTRY? United States
13. FATHER'S NAME Samuel Tarkington			14. MOTHER'S MAIDEN NAME Anna Ritchey		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) no	16. SOCIAL SECURITY NO. unknown		17. INFORMANT & ADDRESS Records of Springfield State Hospital		
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			18. MEDICAL CERTIFICATION		
465X IMMEDIATE CAUSE ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			(A) Gangrene of the lungs with abscess formation (B) Thrombosis of pulmonary artery (C) ---		
			days		
			days		
			years		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			Schizophrenic reaction, paranoid type		
19a. DATE OF OPERATION			19b. MAJOR FINDINGS OF OPERATION		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. PLACE (Home, farm, factory, OF INJURY street, office building, etc.)		
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)			21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		
M.			While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		
22. I hereby certify that I attended the deceased from March 23, 1948, to April 19, 1956, that I last saw the deceased alive on April 19, 1956, and that death occurred at 8:45 P.M. from the causes and on the date stated above.			ADDRESS (Street, city, town, state) DATE SIGNED Martin Gross, M.D. Sykesville, Maryland 4-20-56		
SIGNATURE Martin Gross, M.D.			ADDRESS (Street, city, town, state) DATE SIGNED		
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			DATE THEREOF NAME OF CEMETERY OR CREMATORIUM LOCATION (City, town, or county) (State)		
24. REC'D BY REGISTRAR			REGISTRAR'S SIGNATURE		
DATE 4-21-56			25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS		
C. Harry Zeller			J.S. Meyer Jr. Westminster, Md.		

RECEIVED
APR 24 1956

FEDERAL BUREAU OF INVESTIGATION
U. S. DEPARTMENT OF JUSTICE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3915

CERTIFICATE OF DEATH

03895

Reg. Dist. No. 26

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural Mexico		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Westminster R 4		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural Mexico	
d. STREET ADDRESS Westminster R 4		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Catherine	Middle Arbula	Last Tawney
4. DATE OF DEATH Month April	Month Day 2	Year Year 19 56	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 3, 1887
9. AGE (In years lost birthday) 69 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work	11. KIND OF BUSINESS OR INDUSTRY Own Home	12. BIRTHPLACE (State or foreign country) Carroll County, Md.
13. CITIZEN OF WHAT COUNTRY? USA			
14. FATHER'S NAME Fred C. Feiese		14. MOTHER'S MAIDEN NAME Ida Long	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. - - - - -	
17. INFORMANT		Address Gilbert T. Friese Braddock Heights, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 473 X DUE TO <i>Cleste Cerebral Hemorrhage</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <i>Cleste Nephritis following Cleste</i> DUE TO <i>Housework</i> } (c) <i>Housework</i>		INTERVAL BETWEEN ONSET AND DEATH 24 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) <i>Westminster</i> (Baltimore) (Md.)	
21. I certify that I attended the deceased from <i>March 25, 1956</i> , to <i>April 25, 1956</i> , that I last saw the deceased alive on <i>April 2, 1956</i> , and that death occurred at <i>37</i> , M, from the causes and on the date stated above. ACTUAL SIGNATURE <i>S. Luther Bare</i> ADDRESS (Street, city or town, state) <i>Westminster, Maryland</i> DATE SIGNED <i>4/25/56</i>			
PHYSICIAN'S NAME (Type) S. Luther Bare		79 W. Main St. Westminster, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Apr. 5, 1956	
22c. NAME OF CEMETERY OR CREMATORIUM Leister's		22d. LOCATION (City, town, or county) (State) near Westminster, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John R. Byers		ADDRESS Westminster, Maryland	
24a. REC'D BY REGISTRAR DATE 4-5-56		24b. REGISTRAR'S SIGNATURE Hans J. Muller	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit Permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

302

APR 11

NAME	AGE	SEX	DEATH DATE
EDWARD J. GOLDBECK	50	M	APR 10 1956
ADDRESS		CITY, STATE, ZIP	
1010 E. 36TH ST. BALTIMORE, MD 21218		BALTIMORE, MD 21218	
NAME OF DOCTOR		NAME OF HOSPITAL	
DR. JOHN J. KELLY		BALTIMORE CITY HOSPITAL	
CAUSE OF DEATH			
HEART DISEASE			
TIME OF DEATH			
10:00 PM			
TIME OF CERTIFICATION			
APR 11 1956			
SIGNATURE			
DR. JOHN J. KELLY			

BUREAU V.

APR 9 1956

RECEIVED

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
3916 CERTIFICATE OF DEATH

03896 76
33
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Carroll</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Carroll</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Royal Farmsbury</i>		c. LENGTH OF STAY IN 1b <i>57 yr.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Finksburg Md.</i>		d. STREET ADDRESS <i>Sandybottom</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Landry's</i>						e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>CHARLOTTE</i> Middle <i>M.</i> Last <i>VOGT</i>		4. DATE OF DEATH Month <i>April</i> Day <i>5</i> Year <i>1956</i>					
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Aug 12, 1883</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House-wife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>—</i>		11. BIRTHPLACE (State or foreign country) <i>Washington D.C.</i>		9. AGE (In years lost birthday) <i>72 yrs.</i>	
13. FATHER'S NAME <i>August Giesecke</i>		14. MOTHER'S MAIDEN NAME <i>Lena Seebold</i>				12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>420.1</i>		16. SOCIAL SECURITY NO. <i>—</i>		17. INFORMANT <i>Frank L. Vogg Jr. Finksburg Md.</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Thrombosis</i> DUE TO <i>Suddenly</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Hypertension + arteriosclerosis</i> DUE TO <i>2 yrs.</i> (c) <i>myocarditis chronicity</i> DUE TO <i>decompensating</i> DUE TO <i>1 yr.</i>	
						INTERVAL BETWEEN ONSET AND DEATH	
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day Year Hour o. m. <i>19</i>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> off work <input type="checkbox"/>	
				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Resurrection Md.</i>		20f. (City or town) (County) <i>Reisterstown</i> (State) <i>Md.</i>	
21. I certify that I attended the deceased from <i>1-1-46</i> to <i>4-5-56</i> , that I last saw the deceased alive on <i>2-10-56</i> , and that death occurred at <i>6:15 AM</i> , from the causes and on the date stated above. ACTUAL SIGNATURE <i>James Saffell</i> PHYSICIAN'S NAME (Type) <i>James Saffell</i>				M.D.		ADDRESS (Street, City or town, State) <i>Resurrection Md. 4-5-56</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial April 7-56</i>		22b. DATE THEREOF <i>April 7-56</i>		22c. NAME OF CEMETERY OR Crematory <i>Dund Ridge Cemetery Pikesville, Balt. Co. Md.</i>		22d. LOCATION (City, town, or county) (State) <i>Pikesville, Balt. Co. Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. E. Mulls Jr. Westminister Md.</i>		ADDRESS		24a. REC'D. BY REGISTRAR <i>Howard Elmer</i>		24b. REGISTRAR'S SIGNATURE <i>Harriet Myers</i>	
				DATE <i>4-6-56</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

33

RECEIVED
APR 9 1958
BUREAU V. S.

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

1

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

03897

3917

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>CARROLL</u>	MARYLAND	STATE <u>MD.</u>	COUNTY <u>CARROLL</u>
CITY (If outside corporate limits, write RURAL or and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN <u>R.D. NEW WINDSOR</u>	<u>75 YRS</u>	TOWN <u>R.D. NEW WINDSOR</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>WESTMINSTER</u>	STREET ADDRESS <u>W. BANISTER RD. WESTMINSTER</u>		
3. NAME OF DECEASED (Type or Print)		4. DATE (Month) (Day) (Year)	
(First) <u>MINNIE</u>	(Middle) <u>CATHERINE</u>	(Last) <u>WARNER</u>	OF DEATH <u>APRIL 10 1956</u>
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOW</u>	8. DATE OF BIRTH <u>2-4-1881</u>
9. AGE last birthday <u>75</u>	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u></u>	11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	13. FATHER'S NAME <u>Wm. McCLELLAN</u>	14. MOTHER'S MAIDEN NAME <u>GUSTA STRINE</u>	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>
16. SOCIAL SECURITY NO. <u>NONE</u>	17. INFORMANT & ADDRESS <u>MRS RALPH HULL 94 W. GREEN WESTMINSTER</u>	18. MEDICAL CERTIFICATION	19. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH IMMEDIATE CAUSE (A) <u>Myocardial Failure</u> ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerotic C-V disease</u> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>years</u>
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <input type="checkbox"/> (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Jan 22, 1956</u>, to <u>Apr 10, 1956</u>, that I last saw the deceased alive on <u>Apr 10, 1956</u>, and that death occurred at <u>7 P.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>James J. March</u>	M.D.	ADDRESS (Street, city, town, state) <u>Westminster Md</u>	DATE SIGNED <u>4/11/56</u>
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>	DATE THEREOF <u>4-14-1956</u>	NAME OF CEMETERY OR CREMATORIAL <u>SAMS COPER CEM. DENNINGS</u>	LOCATION (City, town, or county) (State) <u>Westminster Md</u>
24. REC'D BY REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS
DATE <u>4-12-56</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>James H. BANISTER WESTMINSTER MD</u>		

BY FRONTLINE-INTAKE TO TREATMENT STATE AND VARY

HEALTH RECORDS PAGE

ALL INFORMATION

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BUREAU U.S.

APR 16 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3918

CERTIFICATE OF DEATH

03898
74

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be used with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Carroll		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Sykesville		c. LENGTH OF STAY IN 1b 3Y 10M 29 D		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		d. STREET ADDRESS 112 St. Albans Way			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) HELEN		First HELEN	Middle Weir	Last Webster	4. DATE OF DEATH 4	Month 4	Day 12	Year 1956	
5. SEX Female	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 2/27/80		9. AGE (In years last birthday) 76 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (State or foreign country) Ireland		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME William Morrison			14. MOTHER'S MAIDEN NAME Helen Weir Walker						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT		Address Record, Springfield State Hospital, Sykesville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease 420.0								INTERVAL BETWEEN ONSET AND DEATH years 0	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. Septicemia								days 0	
DUE TO (b) Septicemia								days 0	
DUE TO (c) Carbuncle on back								weeks 0	
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Senile brain disease with psychosis; intertrochanteric fracture of left femur - 2/23/56								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) femur - 2/23/56							
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Sykesville		(County) Md.	(State) Md.
21. I certify that I attended the deceased from 2/24/56 , 19 56 , to 4/12 , 19 56 , that I last saw the deceased alive on 4/12 , 19 56 , and that death occurred at 10 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Sykesville, Maryland DATE SIGNED 4/12/56									
ACTUAL SIGNATURE Edmund Lusthaus		M.D.							
PHYSICIAN'S NAME (Type) Edmund Lusthaus, M. D.									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/14/56		22c. NAME OF CEMETERY OR CREMATORIUM London Park Cemetery		22d. LOCATION (City, town, or county) Baltimore, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Ulm. J. Schinner & Sons - Baltimore, Md.		ADDRESS 111 W. 36th Street, New York, N.Y.		24a. REC'D BY REGISTRAR 10		24b. REGISTRAR'S SIGNATURE C. Harry Keay			
VS A15 (4) 1SM 9/55		DATE 4/14/56							

WILSON CENTER FOR SCHOLARLY COMMUNICATIONS

BUREAU Y. S.

APR 16 1958

REGELIVEL

03899

3919 CERTIFICATE OF DEATH

Reg. Dist. No. 71

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 10M

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY CARROLL	MARYLAND	STATE MD.	COUNTY CARROLL
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN FRIZELLBURG		LENGTH OF STAY (In this place) 84 yrs.	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location) FRIZELLBURG	
3. NAME OF DECEASED (Type or Print)		4. DATE (Month) OF DEATH APRIL 27 1956	
5. SEX F	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widow	8. DATE OF BIRTH 1871-10-17
9. AGE last birthday 84 yrs.		10. KIND OF BUSINESS OR INDUSTRY NONE	11. BIRTHPLACE (State or foreign country) MD.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME EPHRIAM HAILEY	
14. MOTHER'S MAIDEN NAME LUCINDA ROUTZAHN		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) NO	
16. SOCIAL SECURITY NO. NONE		17. INFORMANT & ADDRESS D. FRANCIS HAILEY FRIZELLBURG MD.	
18. MEDICAL CERTIFICATION I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH IMMEDIATE CAUSE (A) Cerebral Hemorrhage ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) Arteriosclerosis C-V. disease & hypertension DUE TO (C) years,			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) Westminster (State) Md.		21d. HOW DID INJURY OCCUR? White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
22. I hereby certify that I attended the deceased from Apr 25 1956 , to Apr 27, 1956 , that I last saw the deceased alive on Apr 27, 1956 , and that death occurred at 1450 M, from the causes and on the date stated above. SIGNATURE James J. Marsh ADDRESS (Street, city, town, state) Westminster Md. DATE SIGNED 4/27/57			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		DATE THEREOF 4-30-56	NAME OF CEMETERY OR CREMATORIUM BAUST CEMETERY
24. REC'D BY REGISTRAR DATE 4/30/56		REGISTRAR'S SIGNATURE Margaret P. English	LOCATION (City, town, or county) Westminster Q.D. Md.
		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Bankardson Westminster Md.	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, using the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Forward to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03901
Reg. Dist. No. 80

3920

1. PLACE OF DEATH a. COUNTY CARROLL		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND b. COUNTY CARROLL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) NEW WINDSOR RURAL		c. LENGTH OF STAY IN lb YEARS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 00		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) PERCY		First CLAI	Middle RE
4. DATE OF DEATH APRIL 13 1956		Last WOLFE	Month APRIL Day 13 Year 1956
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH MAY 16 - 1899
9. AGE (In years last birthday) 56 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CONTRACTOR		10b. KIND OF BUSINESS OR INDUSTRY BUILDING	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME WILLIAM H WOLFE		14. MOTHER'S MAIDEN NAME LIZZIE GARBER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 214-14-6982	
17. INFORMANT AGNES WOLFE		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] Hanging	
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) 974X		DUE TO Hanging	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. { (b)		DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) None			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH. Slashed by neck	
20c. TIME OF INJURY Month, Day, Year Hour 6 - 4/13 1956		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) New Windsor Carroll MD	
(County) Carroll		(State) MD	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE James T. Marsh		DATE SIGNED 4/13/56	
EXAMINER'S NAME (Type) JAMES T MARSH		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION REMOVAL (Specify) BURIAL		22b. DATE THEREOF APR 16 - 1956	
22c. NAME OF CEMETERY OR CREMATORIAL WINTERS		22d. LOCATION (City, town, or county) CARROLL Co MD	
(State) MD			
23. FUNERAL DIRECTOR'S SIGNATURE DD Hartzler & Sons New Windsor MD		24a. REC'D BY REGISTRAR DATE APR 14/56	
ADDRESS 100 Main Street New Windsor MD		24b. REGISTRAR'S SIGNATURE Ernest S Benedict	

RECEIVED EXAMINER'S CERTIFICATE OF DEATH		MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE CITY	
SEARCHED	SERIALIZED	INDEXED	FILED
APR 17 1956			
BUREAU V. S.			

RECEIVED
APR 17 1956

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03902

Reg. Dist. No.

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after
may be retained by hospital or attending physician and completely filled in by the funeral director.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

3921		CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY Carroll		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Sykesville		c. LENGTH OF STAY IN 1b 27Y 6M 25D									
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore									
3. NAME OF DECEASED (Type or print)		First Margaret		Middle		Last ZINKHAND		4. DATE OF DEATH 14 11 19 56		Month Year	
5. SEX Female		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH 5/13/74		9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME John Cahill		14. MOTHER'S MAIDEN NAME Elizabeth Doyle									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Record, Springfield State Hospital		Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer of the lung</u>		INTERVAL BETWEEN ONSET AND DEATH Months									
163X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO											
(c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Chronic brain syndrome associated with alcoholism		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Hour a. m. p. m.		Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>4/13/56</u> , 19 <u>56</u> , to <u>4/14/56</u> that I last saw the deceased alive on <u>4/13/56</u> , and that death occurred at <u>12:05A</u> M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED									
ACTUAL SIGNATURE <i>Agustin del Campo</i>		PHYSICIAN'S NAME (Type) <i>Agustin del Campo, Md.</i> Springfield State Hospital <u>4/14/56</u>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <u>4/17/56</u>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Sacred Heart Cemetery</i>		22d. LOCATION (City, town, or county) <i>Hermosa Field</i>		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Jno J. Zalev Sons 1318 Light</i>		ADDRESS <u>APR 17 1956</u>		24a. REC'D BY REGISTRAR <u>C Harry Kerr</u>		24b. REGISTRAR'S SIGNATURE					

TRÉAU V. S.

APR 17 1952

REGELV ELL

THE ASSOCIATION OF HIGH-SCHOOL-TEACHERS

CERTIFICATE OF DATA

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3862

CERTIFICATE OF DEATH

03903

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster		c. LENGTH OF STAY IN 1b 3 months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Union Bridge			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Fringer Nursing Home		e. STREET ADDRESS		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Ella		First	Middle M.	Last Zumbrun	4. DATE OF DEATH April	Month 1,	Day 1956
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH August 5, 1864	9. AGE (In years lost birthday) 91 yrs.	IF UNDER 1 YEAR Months 91	IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Peter Perry		14. MOTHER'S MAIDEN NAME Rachael Fox					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Mrs. Edgar Hockensmith, Taneytown, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 Broncho Pneumonia		DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Arteriosclerotic C-V disease		INTERVAL BETWEEN ONSET AND DEATH 3 days		years	
DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from alive on Mar 31, 1956 , and that death occurred at 1 P.M. from the causes and on the date stated above.				ADDRESS (Street, city or town, state) Taneytown		DATE SIGNED 4/3/56	
ACTUAL SIGNATURE James J. Marsh		M.D.					
PHYSICIAN'S NAME (Type) Merwyn C. Fuss							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 4, 1956	22c. NAME OF CEMETERY OR CREMATORIUM Union Bridge Cemetery	22d. LOCATION (City, town, or county) Union Bridge, Maryland		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Merwyn C. Fuss		ADDRESS Taneytown, Maryland		24a. REC'D BY REGISTRAR DATE 4-5-56		24b. REGISTRAR'S SIGNATURE Hannah Muller	

WILLIAMSBURG STATE POLICE DEPARTMENT - 577 W. BROAD ST.

CERTIFICATE OF DATA

3885

BUREAU V. S.

APR 9 1950

RECEIVED